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A STUDY OF ADMINISTRATION OF STATE PSYCHIATRIC SERVICES*

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ENTERPRISES of moment, whether in business or in government, do not administer themselves. They are administered. Thus the present report begins with an axiom, often much neglected, and too often at the expense of good intentions as well as of good money. In a sense, administration has to do with the shortest distance between two points—*i.e.*, between purpose and performance.

Much of the effectiveness of state psychiatric services, institutional and non-institutional, depends on the kind and

* This article reports the major findings of a project undertaken by the National Association for Mental Health under a research grant from the National Institute of Mental Health of the Public Health Service. The term "we" is employed herein in an editorial sense, reflecting many sources of fact, idea, and opinion, but committing no individual among our numerous informants and consultants, or the members of our advisory panel, to all the views and beliefs expressed. Especially helpful to the director of the project were the advisory panel members: Newton Bigelow, M.D., Commissioner, New York State Department of Mental Hygiene; Ralph M. Chambers, M.D., Chief Inspector, Central Inspection Board, American Psychiatric Association; Maurice R. Davie, Chairman, Department of Sociology, Yale University; Addison M. Duval, M.D., Assistant Superintendent, St. Elizabeths Hospital, Washington; Eli Ginzberg, Professor of Economics, Graduate School of Business, Columbia University; Riley H. Guthrie, M.D., Mental Hospital Adviser, National Institute of Mental Health, of the Public Health Service; Lawrence Kolb, M.D., formerly Assistant Surgeon General, U. S. Public Health Service (Chief of the Mental Hygiene Division); Arthur P. Noyes, M.D., Superintendent, Norristown (Pa.) State Hospital; Winfred Overholser, M.D., Superintendent, St. Elizabeths Hospital, Washington; and George S. Stevenson, M.D., National and International Consultant, The National Association for Mental Health. Charles Buckman, M.D., then Assistant Commissioner of the New York State Department of Mental Hygiene, acted temporarily in place of Commissioner Bigelow. Mrs. Bertha V. Louis served the study as research assistant.

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quality of their administration. For administration is a potent factor in the kind and quality, and even the adequacy, of the services actually rendered—with the ultimate consumer of such services in mind. These truths may be self-evident, but so were several that were deemed worth mentioning in the American Declaration of Independence, and that, like mental health, related to the good things of life, liberty, and the pursuit of happiness. The trouble with self-evident truths, if any, is that sometimes they get overlooked instead of being looked into and acted upon.

A hindrance to public recognition of the administrative factor (itself a complex of factors) in state psychiatric services may be that it has a certain resemblance to Chesterton's "invisible man," who was so obvious and taken-for-granted that he passed unnoticed on the scene of the crime. It is commonly assumed that any public or group enterprise is administered somehow, as of course it is; accordingly, administration may be taken as a matter of course. In this study we have inquired into the "how" of this "somehow."

Aspects of Psychiatric Administration.—The full title of the project was "A Study of Laws and Practices Pertaining to Administration of State Psychiatric Services." Laws, practices, and services have been taken into account, but *administration* is the key word, and administration has been the central object of attention. By "psychiatric services" we refer primarily, but not exclusively, to hospitals for the mentally ill, as administered at the state level; but we have regarded care and treatment in such hospitals as part and parcel of the whole general program of mental health, however it may be divided up, administratively, into bits and pieces.

We have sought answers to the question, How do different forms of organizational setup for administration, and different administrative practices (some of them non-statutory), as found in different states, work to the advantage or to the disadvantage of efficient, effective conduct of state mental-hospital and mental-health programs? By "organizational setup" we mean departments, divisions or units of departments, and boards or commissions; also, various combinations of these elements.

But since performance depends on men as well as on organizational setup, we have considered methods of appoint-

ment and selection, and required qualifications, of top administrators, the people who animate and utilize the setup provided. Other topics listed in the study outline are: the budgeting process for state psychiatric services as affected by the type of setup and as affecting the informativeness of budgetary requests that finally reach the legislature, with respect to actual programs and projects; and any practices or arrangements of whatever sort for coöperation and coördination among agencies, particularly state agencies, that have common interests and allied programs in mental health. All these are but a few of the interrelated aspects or components of the administrative system.

The different systems in the different states are diverse in the extreme, though the job to be done is essentially the same everywhere. Not all of this diversity among the states can be attributed to their relative rates of enlightenment and progress, or to mere "backwardness," though much of it can. Variety, lack of uniformity, is not necessarily or wholly to be deprecated. There are different ways of doing the same thing. The states have somewhat the character of laboratories for working out the best way or ways of administering psychiatric services. This applies in a special context a suggestion made by James Bryce in *The American Commonwealth* about the states and their try-out and testing rôle in experiment.

The states themselves are different in different respects—varying in size and shape, in history, tradition, and culture, and in governmental structure and custom. We need not assume that there is one best, or ideal, form or fashion of psychiatric administration suitable in all details for universal adoption. The states can learn from one another without copying an entire setup or system. Virtues as well as defects may be found in all setups and systems, and so may good hospitals and outstanding programs and services where they might hardly be expected.

Methods and Aims of the Study.—Our methods of investigation have included field visits to selected states (half of the 48) to learn from on-the-spot inquiry and observation about administrative situations and problems that in most of these states had already given rise to acute local concern, at least on the part of certain individuals and groups. We have talked with public officials and private citizens and with both "profes-

sional" and "lay" people (in one sense or another of those terms), seeking facts and opinions from variant points of view and kinds of experience inside or outside of psychiatric administration. Altogether, we have consulted with more than 200 individuals, sometimes in groups, either in the states visited or by conference and correspondence with persons residing in other states. Data have been gathered from all states.

We have also examined the literature of administration in business, industry, and government, not omitting the standard textbooks, the Hoover Commission and Task Force reports on "Organization of the Executive Branch of the Government" (federal), and the reports of the so-called "Little Hoover" commissions on reorganization of state governments. Many of the latter—not all—have treated mental hospitals and health as a matter of subordinate importance in the scheme of state administration, an attitude that we believe to contravene the facts. But these books and reports do reveal a practically unanimous agreement on a whole long catalogue of tried and proven principles of administration which are clearly applicable or adaptable to state psychiatric services as a major function of state government. Around the country, we have found them—some here and some there —widely and frequently disregarded or violated.

Among these principles may be mentioned, as examples: clear placement of responsibility; authority commensurate with responsibility; and a straight line of authority and accountability from top to bottom and bottom to top of the organization. All this implies the avoidance of dual or overlapping authority, not the least of the evils of which is to place subordinates in the dubious and difficult situation of serving two masters. Other essentials of good administration are appropriate qualification for all jobs (at the top as well as at the lower levels of personnel), and appointment for merit only; a staff of technical assistants for the executive head of the organization; and a clear and informative budget that shows both performance and program.

Some Primary Considerations.—We emphasize at the outset three basic facts about state psychiatric services: (1) their integral relationship with administration, (2) their magnitude as big business, and (3) their character as public medicine.

1. The study began with a belief in the vital rôle of *administration* in state psychiatric services. This belief has been confirmed and strengthened. Too little money and too much "politics" have often been cited as the two chief evils afflicting the mental-hospital programs of the states. But administrative setups and systems have a great deal to do with these deficiencies and defects, and with their correction. They affect both the amount of money available and the way the money available is spent, as well as for what purposes. It also appears that some setups for administration are far superior to others from the point of view of excluding undesirable politics; designed for the professional performance of a professional task, they are as nearly politics-free as can be expected under a democratic form of government. Of course, politics isn't all black or white. "Politics is the way the human race behaves when it has democracy," says David Cushman Coyle. It is the citizen's opportunity for good or ill.

We have seen numerous examples of the advantage of putting administration first in efforts to improve psychiatric services—and of the opportunities missed by relying too much on public exposure of bad conditions, or on larger appropriations, without at the same time looking to the organizational setup for administration and its possible improvement. In the alphabet of psychiatric services, the initial letter "A" stands for administration.

2. The fact may be underscored that the mental-health services of the states, institutional and non-institutional, are *big business,* as truly as the manufacture of shoes or steel, though motive and product are different. There is even profit in them of a different kind. So big a business in any state demands that the best tried and proved principles and methods of administration be applied. This is big business in terms not only of financial expenditure and cost—*i.e.,* investment—but of the number of consumers of the product and the number of people employed to bring it to the consumers. Total state expenditures for all facilities and services for the mentally ill, in a recent year, were well over $400,000,000, and for all mental institutions and patients, considerably above $500,000,000. The U. S. Department of Commerce reports that the expenditure of the states for "current operations" totaled nearly five billion dollars, in 1951. On the average, in the 48 states, 8 per cent of this

amount went to mental hospitals, the percentage ranging from 2 to 25. In one large state nearly a third of the operational expenditure is allocated to the purposes and activities of its mental-health department.

The 110,000 or more men and women employed in the state hospitals for mentally ill, with their half million patients, represent an almost infinite variety of professions and occupations, but they are all participants in the same big business of the hospitals. To take a single example, one state hospital serves 30,000 meals daily to its patients, and others—like the first, probably too large—nearly as many. This would be a fairly sizable undertaking for a hotel, which likely enough would rebel at having to give so much room service and prepare so many special diets. But the point is that, in mental hospitals, food and its service are more than business in the ordinary sense; they are part of the extraordinary business of the hospitals—the care and treatment of patients. Hospital business calls for its own special type of administration, at either the state or the local level of operation.

3. We may stress, thirdly, the indubitable, but generally neglected fact that care and treatment in state mental hospitals is *public medicine, public psychiatric medicine,* not private, which most patients cannot afford, even if they and their families are doing pretty well, economically speaking, when mental illness strikes. As the saying is, "life must go on," and it does. The average net loss of future earnings on first admission has been estimated by Benjamin Malzberg as (in New York) $10,000 per male patient and $4,400 per female patient, the patients having an average length of stay in hospitals of a little more than eight years. The total amount thus subtracted from earnings is (in New York) something like 132 million dollars, for the 18,400 first admissions of a single year (1948).

Public psychiatric medicine may not have been bargained for when the "insane" and "indigent" in jails and almshouses were taken over by the states, but the obligation is enforced by the newer knowledge of mental illness and its treatment. The situation must be understood and met, head on. These are the people's hospitals, and we mean hospitals, desirably in the full sense of that term. Most of the care, let alone the treatment, is essentially therapeutic, or should be. Domiciliary care is medically indicated in mental hos-

pitals, just as patients are sent by general practitioners to general hospitals. It is barbarous and cruel to hang up the sign, "Abandon hope, all ye who enter here," and manifestly false to the facts of improvement and recovery. Even if a patient does not get out of hospital, nevertheless this is home away from home. Medical experience gives evidence that hope itself is therapeutic, whether on the patient's or on the doctor's part.

If mental patients have longer hospital stays than others, it is partly because of the nature of their illness. If there is a high proportion of so-called "chronics" in the state hospitals, it is partly because the job of public psychiatric medicine is not well done. There need not be so many chronics or long-term patients. A study at the Stockton State Hospital in California demonstrated that, with adequate staff, from attendants to doctors—nurses, therapists, social workers, and all, and no group more important than another—working as a team on individual cases, and with outside coöperation from family and community, "chronic" is a misnomer in most cases of long-time patients, at least those in whom no organic damage exists.

In another state mental hospital, a canvass was made of all long-time cases on the rolls, showing that many patients were ripe for return to the community, but had been neglected because of staff shortages and could be returned if places were to be found for them to go. None of which implies that a high rate of discharge necessarily means superior care and treatment. It might mean just the opposite—the practice of getting rid of patients as rapidly as possible in order to make room for newcomers.

Since all this is public psychiatric medicine, the public—not only the patients and relatives of patients—have a right to demand that the job be well done, and done as a professional psychiatric job. In committing or accepting a patient, the state—representing society, the people—takes on a clear obligation to see that hospitalization is as effective as possible in terms of results. It has been well said that "in a democracy the citizen has a right to expect what the citizen takes a responsibility for providing." It may be added that a cherished principle of American democracy is that the government belongs to the people, not the people to the govern-

ment. State psychiatric services as a function of the government are no exception. They belong to the people, not to the government. It is not for the people to take what they get from government, but to get what they want through government.

Wanted: 48 Mental-Health Charters.—Good administration depends basically on an organizational setup suited, like a tool, to the requirements of *the job to be done.* In the 48 states, there are more than 48 varieties of setup, though only a few general types, for administration of state psychiatric services. They largely determine the administrative system as a whole—who is responsible for what, with what qualifications and how much authority, and how informatively psychiatric services are budgeted, reflecting both program and performance. Many systems for state psychiatric administration are really not systems at all, but combinations of inherited, obsolete machinery and miscellaneous repairs and additions.

The prime requisite for their improvement and modernization is a clear, definite conception of *the job to be done*—not only care and treatment in mental hospitals for getting patients well or improved or at least more comfortable, but also prevention of unnecessary illness or hospitalization, and the rehabilitation of patients in the community. That is why the Minnesota Mental Health Policy Act seems a step in the right direction as a statement of legislative intentions, though it is limited in scope, covering only a portion of the whole field of mental health. The first "Whereas" says that "mental illness is a sickness with respect to which there should be no stigma or shame." Another: "The State of Minnesota recognizes the necessity of adopting a program which will furnish dignity and hope for the patient, relief from anxiety for the patient's relatives, and recognition for the psychiatric worker." Section I begins: "The measures of service hereinafter set forth are established and prescribed as the goal of the State of Minnesota, in its care and treatment of the mentally ill people of the State."

The aims and objectives of a business, industrial, or civic organization are usually set forth in its charter or constitution or in a formal declaration. Why should not every state enunciate, in clear, considered language, what it is that its

mental-hospital and health activities are for, what they are designed to accomplish, what their product or result is supposed to be? This statement could take the form of a legislative resolution, or a preamble to codified laws pertaining to mental health and hospitals. Such a declaration of purpose and intention could have great educational value, not only through its presence on the statute books, but through the process of preparing and adopting it.

Consciousness of definite aim, if clear and strong enough and if translated into appropriate action, should have its effect on the choice of a suitable organizational setup for accomplishment. In a recent article, *The Decay of State Governments,*[1] Richard L. Neuberger asserted that "state government is attempting to operate with stone-age tools." This assertion, though not referring directly to psychiatric services, bears upon the problem of their administration. What happened is that a century ago, more or less, the states assumed an obligation that they did not and could not then understand in terms of its real nature and potential magnitude. As a measure of practical humanitarianism, what else could be done with the "insane" except to deliver them from the tender mercies of the local units of government and accept them into state care? So in state after state, care of the "insane" came to be established as a welfare function—if indeed it ever got much beyond the institutional concept. True, some notions of curability existed, and some attempts at treatment were made, according to the knowledge of the times, but modern psychiatry and a modern conception of mental illness came later.

The result is that, while the task of state care and treatment has changed, the administrative means and mechanisms for performing it have not changed correspondingly. The tools provided for administration, the setups and systems of most states, remain archaic and inadequate, ill fitted to *the job to be done.* This is what sociologists call the "cultural lag," which sometimes sounds very like a euphemism for citizen inaction and neglect of duty. It is the system that should be adapted to *the job to be done,* rather than the other way around.

[1] In *Harper's Magazine,* October, 1953.

Types and Varieties of Organizational Setup.—What are these types and varieties, and what do they matter to the administration of state psychiatric services? At last reckoning in the fall of 1953, responsibility for the control and management of hospitals for the mentally ill in the 48 states is placed as follows:

In a board or commission	22 states
In a department of welfare or institutions*	15 "
In a separate, coördinate department of mental health	10 "
In a department of public health	1 state

* Four of these are institutional departments.

So broad a classification lacks precise accuracy because of the numerous variations within types. For instance, even the 10 departments of mental health (or hygiene) differ in many important respects.[1] Three of them are headed by administrative boards; six have advisory boards instead; one has neither kind of board. In seven of these states, the commissioner of the department is appointed by the governor and is responsible to him; in one state, he is appointed by the governor, though responsible to the administrative board; in two states, he is appointed by the department's board of administration. In seven of these 10 states, hospital superintendents are appointed by the commissioner (director), but in one of the seven, with the approval of the governor and in another with the consent of the administrative board; in one state, they are appointed by the administrative board; in one, by local boards, otherwise advisory, on the nomination of the commissioner; in one, by local boards (statutorily administrative, but in practice chiefly advisory) with the approval of the commissioner. In seven states the mental-health department is also the "mental-health authority," so designated to administer federal grants-in-aid for mental-health activities outside of mental institutions. In two of the states with mental-health departments, the department has no responsibility for the institution or institutions for the mentally deficient. Such variations as those here mentioned are more significant for our study than the categorical label, mental-health department.

[1] The states that have separate, coördinate departments are California, Connecticut, Kentucky, Maryland, Massachusetts, Michigan, New York, Oklahoma, Tennessee, and Virginia.

The above list of 22 states with a board or commission includes eight in which the one hospital has its own board of trustees or managers. This leaves 14 in which a central board controls a multiple system, in a majority of cases administering not only mental, but other institutions. Some of these boards employ medical or psychiatric directors, with limited powers, or psychiatric consultants without much authority. Considering the fact that three of the mental-health departments have administrative boards, and that five or six of the general departments (of welfare or institutions) in charge of mental institutions also have administrative boards, the number of states in which such boards function with greater or less authority over the hospitals for the mentally ill comes to approximately half of the 48.[1]

Fifteen states have been listed as having placed mental hospitals under a general department of welfare or institutions. The jurisdiction of such a department may embrace not only mental, but correctional and criminal institutions, and institutions and services for public assistance, child welfare, the blind and the deaf, and so on. They are often "basket" or "omnibus" departments, of which we shall speak later. While in more than half of these 15 welfare or institutional departments there are divisions or units specially responsible for mental institutions (from four to more than a score of them), direction or supervision by either a qualified physician or a qualified psychiatrist is lacking, in some instances, even where there are such divisions or units. Other welfare and institutional departments do without such divisions or units and without any psychiatric personnel to direct or supervise the mental institutions, operating in the central and controlling office on a "lay" basis.

Setups as a Matter of Choice.—Good and bad features—from an administrative standpoint—overlap any broad classification of setups. A mental-hygiene department and a mental-hygiene division may be more alike in certain significant ways than two mental-hygiene departments, though

[1] A difficulty in the way of exact classification lies in the divergence between statutory provision and actual practice, not to mention the vagueness and ambiguity of statutory language. The laws do not always mean what they say, or say what they mean. Varying interpretations are possible, and the practice may be better than the law, or vice versa.

equally significant differences may exist. Several of the state boards of administration are concerned with mental institutions only, not with varied and different kinds of institution, and so have a certain singleness of purpose and function. In one state the mental-health commission, though not ranking as a separate, coördinate department, is concerned exclusively with a unified, comprehensive system of mental health—mental institutions and clinics—and is the designated "mental-health authority" for conducting the non-institutional program of community services. With its director, it functions apparently as much like a department—separate, though not coördinate—as some so-called departments.

A setup for state psychiatric services, in other words, is to be judged not alone by its name or general type, but by its good and bad features, its component elements. One can hardly expect that a state will change its setup except in response to a "felt need," some dissatisfaction with the workings and results of the existing system of which the setup is the core. Then it should seek to adopt such a setup and system as will embody the best features and established principles of administration. We do not essay to prescribe any ideal or model setup or system for each and every state, but we do conclude from our study that the separate, coördinate department of mental health is the form of organization most likely to represent these good features and proven principles.

While the terms, "setup" and "system," have been used more or less synonymously, the former is intended to stress primarily the agency of the state charged with mental-hospital or mental-hospital and mental-health administration—that is, the kind of agency, whether a department, division, or board. With special reference to the institutional aspect of mental-health administration, what does the setup really matter? Just a few of the questions whose answers depend on the type and variety of setup are as follows:

1. Has the state, or does it attempt to have, such a thing as a planned and coördinated program for mental institutions?
2. Is there any place or position for a director of these institutions, whatever his qualifications?
3. Can a competent, qualified psychiatric director, if any, operate with freedom and authority, and without undue handicap and frustration, in doing his work?

4. Can the state get and hold a fully qualified psychiatric director under conditions of inadequate salary and insufficient opportunity?
5. Is there a separate budget for the institutional program, to be clearly seen, understood, and acted upon?
6. Are budgetary requests, properly prepared, presented by some one with close access to budget chief, governor, and legislature, and with full knowledge of the needs of and with partisan concern for hospitals and patients?

Some setups meet these indicated standards and requirements for administration of state psychiatric services; others stand in the way of meeting them. The above questions could be phrased to apply to a broader than institutional program under the institutional authority.

On our field visits we heard such variant expressions of opinion as: "If we had a better man at the head of the system, everything would be fine and dandy"; and again, sometimes even in the same state, "If we only had a better system, everything would be all right. We have a top-notch administrator, psychiatrically trained and experienced, with the highest qualities of vision, imagination, and leadership." We were told that any system will work well with a good man to run it; also, that this is arrant nonsense. The truth seems to be that any system will work better under a good man, but that a poor system is still a poor system that hinders and handicaps the best of men. Thus the problem of man *versus* system becomes that of man *and* system, each complementing the other.

Take a couple of cases. In one of the states visited, the situation was presented of overlapping authority, divided three ways—between the administrative board (of multiple membership, of course), its executive (business) director, and its medical (psychiatric) director. The latter resigned, to the great disappointment and regret of leading citizens interested in the mental-hospital program. They felt that the filling of the vacancy by the appointment of another man could prove no solution to the problem of real and continued progress in improving the hospitals, since he would succeed to the same old irksome and frustrating situation of limited power to act. They saw the imperative need as a radical change of administrative setup, so that a good man would have a fair chance to accomplish things.

Another state recently appropriated some millions of dol-

lars for mental institutions, after the public had been aroused over deplorable conditions by newspapers and the appropriations committee of the legislature. A number of citizens who supported this *ad hoc* measure expressed the opinion, however, that a step equally if not more important would have been to improve the administrative setup. True, there was a division of mental hospitals in a general department, but no psychiatrically trained and experienced head of it, and no central psychiatric program of control and supervision of the institutions, which virtually went their own separate and uncoördinated ways. The money, it was suggested, might indeed be better spent if there were a continuing and coördinated program for the state mental institutions under technically qualified direction and leadership.

A further word on this subject of man *and* system: in order to have *career men* in administrative positions at the state level, it is essential to have or to establish *career jobs* that are attractive and satisfying to such men, and so have "holding power." The high rate of turnover in these posts, the large amount of transiency and itinerancy, is regrettable. In one state welfare department there were four successive chiefs of the mental-hygiene division in six years, whatever the reasons. The setup or system was certainly one of them.

Of Boards and Commissions.—These are here considered generically, though in textbook literature a sharp technical distinction is drawn between "board" and "commission." However, no uniform usage is followed by the states with respect to these terms in designating the agency responsible for administering state psychiatric services, particularly the hospitals. In a number of states, in fact, an administrative or advisory board is called a "board of commissioners"—really a contradiction in terms. Reasons for the prevalence of administrative boards include:

1. The idea that many heads are better than one. This is a good idea gone wrong, by misapplication. Another and equally valid saying has it that too many cooks spoil the broth.

2. The old-time fear of one-man authority, the idea of safety in numbers. According to the Book of Proverbs, in the Bible, "In the multitude of counselors there is safety," or, as sometimes quoted, "wisdom."

3. The fondness of governors and politicians for boards, the more the better and, in cases, the more members the better. Patronage is involved, not necessarily of evil intent or character.

4. The long-established "board habit." Many states have run to boards from away back. The system is hard to change, as are other personal and governmental habits.

5. The "vested interests" of board members. These may or may not be political or financial or of shady repute. For "vested interests" may consist of such things as pride in office-holding, public recognition, and a sense of rendering public service.

Among different kinds of board, we may list: administrative boards; advisory or advisory-visiting boards; boards (more properly called commissions) with regulatory, quasi-legislative, or quasi-judicial functions; boards with so-called "policy-making" powers; and boards of mixed type or function.

It is principally with the first type of board that we are immediately concerned. Mental institutions, in nearly half of the states, are under boards that have full or partial powers and duties of control and management. Expert opinion is unanimously adverse on the subject of boards as agencies of administration. Urwick, in *The Elements of Administration*,[1] quotes from *The Report of the President's Committee on Administrative Management* (1937), by Luther H. Gulick and others, as follows:

"For purposes of management, boards and commissions have turned out to be failures. Their mechanism is inevitably slow, cumbersome, wasteful and ineffective and does not lend itself readily to coöperation with other agencies. . . . The conspicuously well-managed administrative units in the Government are almost without exception headed by single administrators."

The same report says:

"We have watched the growth of boards and commissions transform the executive branches of our state governments into grotesque agglomerations of independent and irresponsible units, bogged by the weight and confusion of the whole crazy structure. . . . That tendency should be stopped."

The tendency may have been stopped, but not the thing itself. Reports of the death of this dodo of administration have been greatly exaggerated. The "Hoover Commission" of only a few years ago (on "Organization of the Executive Branch of the Government") found it still timely and worth while to say that multiple executives—*i.e.*, boards—are not nearly as efficient or effective as single executives, and to declare positively for the departmental form of organization,

[1] New York: Harper and Brothers, 1943.

with each unit centered around a group of related functions and under a single head whose jurisdiction is clearly defined. The same ideas have been expressed by the "Little Hoover" commissions of a number of states.

The fact remains, however, that in fully half of the states administrative authority over the mental hospitals is completely or partially vested in a board; and this is all at the state level, and no account is taken of the individual hospitals and their own separate boards with anachronistic powers and duties.

As William H. Newman points out in his book, *Administrative Action,*[1] the use of committees, boards, councils, and similar groups as an administrative device may be traced back to Greek, Roman, and other ancient civilizations. Assuredly it bears some of the earmarks of antiquity. However, "it has been particularly popular," says Professor Newman, "in Anglo-Saxon countries where it has often been regarded as an aspect of democracy." He adds: "In spite of generations of diverse experience with the use of committees, there is no administrative device more commonly abused." This assuredly does not mean that all boards are bad. Distinction must be made among the different purposes and functions for which boards are used, and so among the different kinds of board. It is conceded by all experts on administration that for proper and appropriate purposes, boards can be extremely useful and may indeed be necessary. Boards, committees, and such are all right in their place, but it is generally agreed that their place is not in situations where the problem is primarily that of management or execution. For management or execution a committee of one is probably the most desirable.

Chief faults of administrative boards may be summarized as: (1) slowness of decision and action; (2) dispersal of responsibility to the point of irresponsibility; and (3) domination by one or more members, or executive action taken by chairman or secretary. One of the greatest shortcomings lies in the handicap to coöperative relations with other agencies of government—that is, the difficulty of participating responsibly in inter-agency discussion and agreement. For the multiple board cannot agree to any joint policy or action, in conjunction with such other agencies, until the members of

[1] New York: Prentice Hall, 1951.

the board have made up their own minds, and that may take time. We have even heard it complained that board members waste a lot of time at meetings by talking too much about the weather, the crops, politics, and such-like matters.

Perhaps the best way to understand the real trouble is to visualize an administrative board trying to act like an administrator. And to ask who is administrator when the board adjourns one of its meetings? The chairman, or the secretary, or the "big shot" on the board? It has to be somebody, in person; for the board, as such, ceases to exist when it adjourns, leaving a lot of business unfinished, and a lot more coming up. The patients can wait and "eat cake." Think of all the things a hospital superintendent serving under an administrative board may have to take up with his board at its next meeting—even the repair of a corridor floor in bad condition. Or consider the dilemma of a local board required by law to pass on all discharges. It must either trust the judgment of the superintendent, or exercise its own. But how can it do the latter without technical competence and full and competent knowledge of the cases? And why duplicate functions?

Many other duties and responsibilities are entrusted to boards that are of a professional or technical nature. If a state or local board includes in its membership a professional or two—say, a psychiatrist, and even he is not the whole board—what can properly and usefully be his rôle in actual administration? One-man authority is enough. Two authorities are one too many.

The foregoing remarks are not intended as a reflection on all boards, certainly none on advisory boards, which can be of great help in the task of administration. The President's Committee, already quoted, said: "When freed from the work of management, boards are . . . extremely useful and necessary for consultation, discussion and advice; for representation of diverse views and citizen opinion; for quasi-judicial action; and as a repository of corporate powers."

We have noted in recent legislation in certain states what may be regarded as a tendency in the direction of advisory instead of administrative boards for the state-hospital authority and for individual hospitals. We have also noticed, in places around the country, that local boards with adminis-

trative powers under the law have become in practice chiefly advisory, without legal change. In other words, they have ceased to try to administrate, and have put their faith voluntarily in the hospital superintendent. This may be due in part to realization, from their own experience, of the fact that boards don't work very well as agencies of administration. However, in these instances, the powers remain, and the danger is that where they exist, they will be used—perhaps for purposes of "passing the buck" between board and administrator for failures of performance.

In one state, it is found that while a few of the boards may be operating in the rôle of aiding the superintendent with counsel, information, and support, other boards—or some members of them—in the same state meddle constantly in hospital affairs, particularly in personnel matters, dictating by one means or another who shall be hired and who shall be fired.

An advisory board as an adjunct either to the state mental-hospital agency or to a mental hospital can easily fail by succumbing to "innocuous desuetude," if not given something definite to do—some specific duties, not powers. Such duties may, and in instances do, include visits to hospitals, conferences with the commissioner (or superintendent), and periodical reports, besides serving the general purpose of "consultation, advice, and guidance." In one state, the commissioner is required to consult with the advisory board in "professional and technical matters," and it is with the approval of this board that the governor appoints the commissioner. Some of our consultants object to the professional board on the ground that it introduces an element of telling the commissioner or superintendent what to do and how to do it. They favor, instead, a board or committee made up of representatives from varied fields, such as law, education, business, labor, social work, and "civic" activity. It is the valuable function of this kind of board to provide a liaison, or two-way means of interpretation, between the hospital management and different groups in the community.

In a certain state, the question was raised whether it would not be desirable to reëstablish the former board of administration, which had been superseded by a department of mental health, so that the commissioner could profit by "the board's

interpretation of the state scene, its feelings, its customs, and its resources." Why not an advisory, not administrative board, to perform this service of interpretation, as a two-way, not a one-way service, instead of taking a step backward from the departmental form of organization?

Advisory boards are not, and need not be, of any single type; they serve a variety of purposes. The advisory committee of the California department of mental hygiene, which advises the department on policies and programs, is set up in such a way that there are two working units—one especially interested in the hospitals, and the other in community programs, to the latter of which is delegated the additional task of advising the department director, in his capacity of "mental-health authority," as to the use of federal funds allocated under the National Mental Health Act. At last report, the department was in process of setting up advisory boards for the state's all-purpose outpatient mental-hygiene clinics. Some advisory boards undertake occasional and special projects of investigation, on such topics as the desirability of a central-office post for guidance and supervision of volunteer services in the hospitals, or the amount of dangerous or antisocial behavior on the part of released patients.

Advisory boards, policy-making or quasi-legislative boards, and boards with quasi-judicial powers and duties fall into different categories from managing boards. A conspicuous example of how managerial or executive functions may get mixed up with other and irrelevant functions in a single board is found in the New York Civil Service Commission before its recent reorganization. This was a "board" with complete administrative powers shared together by its three members. A "Little Hoover" commission reported that the setup resulted in confusion as to administrative responsibilities, undue delays in administrative decison, and inconsistencies in action and decision. Under the new law, the Civil Service Commission is still a three-member body, but the administrative responsibility and authority are separated from the quasi-judicial functions of the department and placed in the hands of the commission's president, while the group as a whole retains appropriate powers in matters

involving rule-making, appellate review, and supervision of the civil service.

In the field of psychiatric administration, a similar mixture of dissimilar functions in a single board is sometimes found. We are more than a bit skeptical of the validity of so-called "policy-making" powers in boards that have to do with mental hospitals. Policies would seem to be largely implicit in the task of mental-hospital administration—that is, in the nature of the task itself; they are implied by the legislature in setting the task. It is the word "making" to which we object. If policies are *made* by a board, the commissioner or superintendent is thereby limited both in his responsibility and in his authority. His accountability to governor and people—and to himself—for doing the best job of which he is capable according to his lights, is diminished. We believe that policy-*making* by a board savors of divided responsibility for management and direction, but that counsel on policies and practices, plans and procedures, is a proper, useful function and responsibility of advisory boards.

A word or two should be added about *ex-officio* boards of administration. These are found in several states in the field of psychiatric administration. As Austin F. Macdonald says in his book, *American State Government and Administration:*[1] "One of the most ineffective devices yet conceived for the performance of administrative duties is the *ex-officio* board—that is, a board whose members serve by virtue of holding certain designated offices," usually elective, as those of governor, attorney general, comptroller, and so on. Some states make widespread use of such boards, apparently as "a cheap means of carrying on necessary administrative activities." In one state, this *ex-officio* board for control and management of institutions, including mental, in accordance with a constitution of 1868, consists of governor, secretary of state, attorney general, state treasurer, comptroller, commissioner of education, and commissioner of agriculture. This sort of setup is obviously unfair both to the board members, who have other duties to perform, and to the mental institutions, since the board members are unlikely to be specially qualified for direction and supervision of such institutions, and do not have time enough for such functions.

[1] New York: T. Y. Crowell, 1950.

Of Departments and Their Kinds.—The trend in the movement of the past few decades to improve efficiency in government has been decidedly toward the departmental form of organization for administrative purposes. This is true both of federal and of state government, and of the recommendations both of the so-called Hoover Commission in the federal area and of the "Little Hoover" commissions in the states.

As pointed out in the Task Force reports of the federal commission, distinction must be made between the "integrated" type and the "holding-company" type of department. The tasks and activities of the integrated department are closely and functionally interrelated, and its component units are closely knit together; it has a single mission to perform. Most of the administrative responsibility is vested in the department head himself. On the other hand, in the holding-company type of department, diverse and often divergent tasks and activities are found, some of them only remotely related one to another. Administrative authority is vested chiefly in divisional or bureau heads, the department head having only or mostly coördinating and supervising functions. Says a Task Force report, referring specifically to federal agencies:

> "The holding-company type of departmental organization may be necessary under certain circumstances, but in general we believe that such a structural arrangement is undesirable and should be eliminated wherever possible. . . . The holding-company type of department in which constituent units have been given separate legal authorization prevents a department head not only from introducing organizational improvements which may seem desirable, but also from exercising authority commensurate with responsibility. When the holding-company type of department is set up, it should be given something more positive to do than merely to direct and supervise the work of the constituent units."

Among principles or essentials of good administration relative to state governmental services, recognized and enunciated by most students of the subject, including the "Little Hoover" commissions, are these:

> 1. The establishment, in place of a multiplicity of offices, boards, agencies, and so on, of separate integrated departments, each concerned with a major function of government.
>
> 2. The assignment of each such department to the charge of a single administrator, appointed by and responsible to the governor, and having authority commensurate with responsibility.

The effect of these arrangements is to place administrative responsibility squarely on the shoulders of the governor as the chief executive officer of the state, and just as squarely on those of his subordinate, the department director, for the conduct of the work of the department.

The "Little Hoover" commissions declare unanimously for "functional departmentalization of administrative agencies" and for "integrated departments." But what happens, usually? After enumerating certain principal departments in their organization plans—as those of finance, agriculture, public welfare, public works, and so on—and trying to keep the number of departments down to ten or fifteen or a score, they put the leftover governmental functions into one of the enumerated departments, such as welfare, and call it "integrated." Mental health is frequently one of the leftovers, not regarded as a major function of state government.

One state legislature, adopting the recommendations of a reorganization commission, established a department of health, welfare, and correction, out of the numerous existing boards, departments, and agencies, to have responsibility for the administration of "the health, welfare, correction, probation and parole, and institutional care and training programs of the state government," the mental institutions, along with others being assigned to a division of institutions, subject to the "policies and procedures" of the divisions of public health, public welfare, and detention and correction. At the next session the legislature, thinking better of it, rescinded the action, and abolished the department.

This was an omnibus department on paper, but such departments are not all on paper; a good many are actual, among them a number in which the mental-hospital program has only a subordinate or it may be a toe-hold place. Now, obviously, a mere agglomeration of administrative tasks and services does not always spell integration, in any true sense of the term; and a "basket" or Sears-Roebuck type of department is not—or not necessarily, at any rate—the same thing as an "integrated" department, as advocated by students and experts in government administration. It might on first glance more nearly resemble the "holding-company" type, as above described. But an important difference in the omnibus departments that embrace mental institutions

is that much, most, or all of the responsibility for the administration of the mental-hospital program is legislatively vested in the department and the department chief, with the result that the head of the division, bureau, or unit, or the commissioner's deputy, for mental institutions has limited responsibility and authority, two things that belong together, each equal in importance to the other. Indeed there may not be any special division or deputy for mental hygiene in such a setup.

Welfare departments may be omnibus departments, "welfare" being an omnibus word in this connection. They encompass such a wide variety of responsibilities and services as public relief, child welfare, correctional and penal institutions, tuberculosis sanitariums, mental institutions, homes for the aged, orphanages, soldiers' homes, schools for the blind and the deaf, and so forth. Economy is a principal reason, frankly given, for omnibus departments, their recommendation and existence being justified on grounds of common housekeeping and institutional arrangements. A principal reason for dumping mental institutions into an omnibus department is to save dollars and cents. We doubt that it does.

Nobody disparages economy or business efficiency in the conduct of mental institutions and related services. But the question is whether there has not been a disposition, in this emphasis on economy, to put the cart before the horse. The true economy may lie in doing the best job possible in the care and treatment of patients, preventing mental illness and hospitalization, shortening hospital stay, and rehabilitating patients—in short, in doing the best possible psychiatric job, putting the patient first.

It is quite unnecessary to point out the social and economic savings to state and society of putting the emphasis in psychiatric administration where it belongs—on psychiatric services. In planning or choosing organizational set-ups, this is the kind of economy that should have first consideration, business and financial economy taking second place, but having such place. The sick person comes before the dollar, but the well person saves dollars, too, besides adding to human happiness, which is an asset to state and nation.

To get back to the question of integration and integrated

departments, the legislature of a certain state has lately broken up its omnibus welfare department by creating out of it a department of mental hygiene and correction. The new law has not yet gone into effect. But how much integration there can be between correction and punishment on the one hand, and mental health on the other, is a bit dubious. Certainly it is an excellent idea to treat delinquents and criminals, even in confinement, as mental cases, but it is quite another thing to convey the suggestion that mental illness is to be associated with crime, or that mental patients are also prisoners. In the present state of affairs, such matters as food, clothing, and shelter are generally regarded by psychiatrists as aspects of therapy, but by administrative criminologists merely as food, clothing, and shelter. A similar difference of attitude applies to work and play—unfortunate perhaps, but still there is this wide difference in attitude and practice. Not that there are not some modern-minded criminologists, but that criminology has not yet caught up with modern psychiatry, especially as regards institutions and institutional care.

More About Kinds of Department.—From the standpoint of state psychiatric services—which is ours—there are a number of handicaps and disadvantages in the placement of such services in a general or omnibus department:

1. Lack of a truly functional integration with the department as a whole, and a consequent lack of real belongingness of the psychiatric services in such a department. A mental-hygiene division, if any, usually has too little freedom of decision and action in its own field. Administration of mental-hospital care is a stepchild of public welfare and institutions, but has grown beyond childhood to the stature, if not the status, of independent adulthood. It should be emancipated.

2. The department commissioner is responsible to the governor, and the divisional head to the commissioner, which is quite according to Hoyle. But where does this leave the divisional head for mental hygiene? Many or most of the powers and duities pertaining to the department, including its divisions, are likely to be vested in the commissioner, or to be divided confusingly between him and the divisional chief. The commissioner may exercise his superior powers

even in medical and psychiatric matters. He may appoint the hospital superintendents, in violation of the administrative principle of "chain of command and accountability." The responsibility, at least nominal, of the mental-hygiene chief may not be accompanied by commensurate authority, in violation of another administrative principle.

3. Thus it happens that "dual authority," or administrative schizophrenia, is a common ailment of omnibus departments. There is a division or overlapping of authority not only between the divisional and the departmental chief, but between the mental-hygiene head and the business administration head. No hard-and-fast line can be drawn between psychiatric and business affairs. The psychiatrist regards food, clothing, and shelter as therapeutic agents; not so the business man as business man, who may want them cheap. If mirrors are to be provided for patients so that they can see themselves, let them not be of the cheap distorting variety like those in a Coney Island "crazy house." It certainly was not a trained and experienced psychiatrist, in control of affairs, who ordered unsuitable surgical supplies because they could be purchased at a bargain, or who planned a building in which aged patients were to be placed in an upper storey, or a cafeteria that was unusable by infirm patients, or the installation of urinals in a women's ward.

4. Assuredly one cannot expect that the commissioner of an omnibus or basket department will be an expert in all fields of activity within it, or be a Jack-of-all-trades. He may indeed be a master of one of these fields, and so tend to give special attention to that. He may be a political appointee and not well versed in any of them. However, the question at issue is not this so much as it is the effect on his divisional heads, who are presumably chosen for their special competence and expertness. How do they fare with respect to freedom and opportunity to do their professional stuff? The commissioner having superior authority over the affairs of the department, the temptation is to exercise it, with or without sufficient knowledge and with or without sufficient allowance and delegation of powers and duties to those working under him as professional chiefs of divisions. All of which affects their feelings of job satisfaction, of profes-

sional self-respect and personal dignity, and of pride in accomplishment.

5. It also affects the attractiveness and holding power of their jobs. Another element in this, frequently with particular reference to the trained and experienced psychiatrist, is inadequate salary. The psychiatric administrator may be paid either less or more than his superior officer. In the first case, it is probably too little as compared with what he could command in private practice; in the latter, it may be a source of jealousy and friction. The head of the mental-hygiene division may receive, not an excessive salary, but a larger one than that of any other official in the state government, a situation which leads to the criticism that it is "out of line." Less criticism is evoked if the adequate salary is paid to the commissioner of a mental-health department.

We do not wish to overstress the salary factor, but it does have a place in administrative ill-health. To a minor extent, along with dual or divided authority, and impotence and frustration in doing the job, it does play a part in the excessive turnover in positions of divisional responsibility for state psychiatric services.

6. A further disability of psychiatric services, if placed in an omnibus department, lies in the fact that the department head, not the psychiatric head, has the contacts with the governor and his ear for purposes of information and interpretation. This is perhaps as much of a handicap to the governor as to the mental-hygiene chief.

7. It happens, too, that a mental-hospital and mental-health budget, where mental hygiene is located in an omnibus department, may be and often is merged and submerged in the departmental budget, so that no clear picture of hospital and patient needs emerges in the budget proposals as acted upon by finance officials, the governor, and the legislature. Even if the original requests for mental-hospital and mental-health purposes do become available, beyond the department, to the governor and his advisers, there may be no provision whereby the published governor's budget, as it reaches the legislature and public, contains the data on which the request for mental-hygiene services was based. Maintenance and personnel items, for instance, may be lumped with those for the

rest of the department. And while budget requests and recommendations may not be at all indicative either of performance or of program, that is a common fault in budgeting, not limited to mental-hygiene services. Far superior to the "line item budget," which lists, for instance, total number of employees and their salaries, is one that shows the costs of particular operations and projects, the personnel required for these tasks, and other expenditures involved therein.

Citizen groups here and there, becoming aware of the defects and shortcomings of omnibus departments in matters of administration, have considered means of improvement. One suggestion is that legislative action be taken to give the mental-hygiene division (with other divisions) a larger degree of responsibility and authority—that is, more autonomy. This step would diminish the rôle of the department as such, weaken its place in the administrative scheme of things, and so result in something like a holding-company type of organization, which would be undesirable. What is needed, in place of either a holding-company or an omnibus department, is a department not too wide in scope or variegated in function for operational integration and unity. This would mean a splitting-up of conglomerate departments and an increase in the number of departments.

The number of departments, however, is not nearly so important as efficiency and effectiveness in administration. If governors find it hard to keep informed of the work of many departments, they could have two or more cabinets or groups of department heads, sometimes meeting separately, sometimes together—an arrangement that has the approval of informal and occasional practice in a few states. One group might consist of heads of departments that deal especially with what may be called the "human" problems—the health, mental-health, education, welfare, and like departments—and the other group, of department heads concerned with business, finance, highways, and so on—that is, with the "practical" problems of state government (if indeed, they are any more practical than the others). There might even be an assistant governor (with whatever title) to help the elected governor in maintaining close relations with departments and department heads.

Another suggested means for the improvement of omnibus

departments, in the matter of mental-hygiene services, is legislative provision whereby the budgetary request for the mental-hygiene division be kept separate from other departmental needs in the published "governor's budget" as presented to the legislature. This would enable the legislature to know what is being requested for mental hygiene, and the mental-hygiene director to know what the legislature has actually appropriated for the work of his division. Otherwise there can be no such thing as a mental-hygiene budget.

In making any changes in the administrative setup as affecting hospitals and health, a state should be careful not to compromise with eventual goals. Changes in the direction of a desirable eventual setup are one thing; but changes that stymie further changes in that direction, or that turn the clock back, are another. An improvement or strengthening of a divisional setup in a given state *may* be a step toward establishing a separate department, since it may demonstrate how much more desirable it might be to have a department than a division, with its various limitations and handicaps.

For a Separate, Coördinate Department.—In place of administrative boards and omnibus departments, with all their defects and deficiencies in the conduct of state psychiatric services, we urge the desirability for most states, certainly those with three or more mental institutions, of a separate department, coördinate with other departments, for mental-health administration:

1. Such department to be headed by a commissioner or director (see qualifications below) vested with full responsibility and commensurate authority for running the department (subject only to the responsibilities inherent in the governor, the legislature, and the courts). This recognizes the administrative principles of clear placement of responsibility, of one-man responsibility, and of authority commensurate with responsibility.

2. Such commissioner to be appointed by and responsible to the governor. This recognizes the rôle of the governor, under our governmental system, as chief executive of the state.

3. Hospital superintendents to be appointed by and responsible to the commissioner. This is in accordance with the administrative principle of the so-called chain of command and accountability—governor, commissioner, superintendents; the commissioner's staff to be under his sole direction; the superintendent's under the latter's direction.

4. Interposition of an administrative board between commissioner and governor, or other form of dual authority, to be avoided. An advisory board appointed by the governor for overlapping terms could be helpful.

5. The department to be concerned not only with care and treatment in mental institutions, but with extra-institutional mental-health pro-

grams—*e.g.*, community services, comprehensive outpatient clinics, prevention of mental illness, and follow-up and rehabilitation of mental patients. Thus, an "integrated department" with a single mission to perform (all its activities being closely related).

Such a department would lend itself to complete coördination of all departmental activities. Internal organization would conform to its single program of a comprehensive mental-health program, unified and centralized. Further specific advantages include: (1) a budget prepared and acted upon, clearly, *as* a mental-hygiene budget, not merged or submerged with other matters; and (2) opportunity, as well as need, to head the department with an administrator especially and fully qualified in the department's field of work.

This latter is a chief advantage. The commissioner of such a department, properly organized, without overlappings or conflicts of authority within it, has freedom:

1. To go ahead and do the best work of which he is capable, since he is the boss (within the department).
2. To meet and confer with the heads of other departments and agencies on equal terms, for purposes of coöperation and coördination of activities and programs.
3. To make decisions *in re* policies and procedures without being subjected to any right of veto, and to establish such uniform rules and regulations as he sees fit.
4. To exercise, for example, his judgment and authority in the preparation of the budget, and in so doing, to consider such items as food, clothing, and shelter from the psychiatric standpoint, not merely that of business and cost.
5. To talk with the state budget officer, civil-service officials, and the chairmen of legislative committees, without any superior intermediary or interference.

The commissioner has greater standing with the legislature, as a member of the governor's official family, than he would have as a departmental subordinate. As commissioner, he has greater freedom as well as opportunity in the exercise of leadership, and he is more likely to be paid an adequate salary—high enough to get and hold a good man—though he will find his chief satisfaction in freedom and creative expression.

Opposition to the establishment of a separate department has been due to the following among other factors:

1. Desire to keep the governor's official family small, not adding any more members.

2. Fear of the increased cost of state government, a dollars-and-cents attitude.
3. Protection of vested interests by officials already in charge of the administration of mental institutions. It could be that "political patronage" is involved.

These considerations have resulted in the exercise of a sort of "birth control" over new and separate departments. In the case of a mental-health department, we might mention the lack of a definite, stated policy reflecting the duty of the state regarding mental illness.

Establishment of a separate department of mental hospitals and health would add only one person to the list of those directly responsible to the governor. But it would make it easier for the governor to keep well and fully informed about one of his chief responsibilities to the people.

Regarding increased costs, it should be remembered that mental institutions, representing the bulk of mental-health expenditures, are always somewhere in the state government. They are not a fresh obligation. Various "common services" —legal, architectural, constructional, those of purchase and supply, and so on—would still be available. The chief prospect of additional costs would probably lie in the possibility of a bigger and better program, better staffed, with more concentration on the mission to be performed. According to a popular saying, a job worth doing is worth doing well.

In one of the states that recently established a separate department, it was found that administration costs for the department ran about the same as for the previous division in another department. However, we make no argument of that. Keeping costs down is no reason at all for not choosing the most desirable administrative setup. By all standards, the states do not pay enough for the care and treatment of mental patients or for other psychiatric services—not nearly enough. The fear of spending may limit the quality of spending.

Tennessee is a state in which the state psychiatric hospitals had been administered along with the correctional and penal institutions prior to the establishment of a separate department of mental health. Leaders in Tennessee felt that the change just *had* to be made, so the state made it. There were

no serious objections to this legislation. It was something the leaders and people in Tennessee came to believe in. We are permitted to quote from a letter received from Dr. C. J. Ruilmann, commissioner of the new department of mental health:

> "It is my opinion that in the State of Tennessee more money will be spent in caring for psychiatric patients than has been true in the past. I do not believe this reflects particularly increased administration costs, but rather a greater recognition on the part of the state administration as well as the citizens of the state that more money needs to be spent. I have no doubt that purely custodial care of patients can be accomplished for a very nominal sum of money, provided one's interest is attracted by the cost per patient per day. This, however, should not be the objective of a psychiatric hospital. Even though there are unsolved problems in the care of the mentally ill, one must not lose sight of the fact that the important criterion is the number of days lost from productive living by the patient and not the cost per day while in the hospital. It is our plan to push a double-barreled program aimed, on the one hand, at improving the efficiency of our large state hospitals, and on the other, at constructing a series of outpatient community service facilities with which we hope to prevent hospitalization in as many cases as possible and to look after the all-important matter of post-discharge care for the patient. We are already involved in a number of joint projects involving other state departments; notably, the departments of health, education, and welfare. We have not found any difficulties in getting coöperation from the other departments."

This is a clear statement of the purpose and program of a separate, coördinate department of mental health. It is also indicative of great promise, not only to Tennessee, but to other states that have or contemplate so propitious a setup for the administration of state psychiatric services.

To go on record in favor of a mental-health department in every state "with three or more mental institutions" does not mean disapproval of such departments in other states with fewer institutions. The number of institutions is no proper criterion of the desirability of a mental-health department, though that and the general population of the state may be taken as indications. (The institutions may be too few for the size of the general population, and too large.) The principle of functional organization can be applied in any state to its administrative services. Widespread and expert opinion has been expressed that even in small states a central mental-health department might be constituted to include not only mental institutions, but community-clinic and other mental-health activities—in short, a complete institutional

and non-institutional program for care and treatment plus prevention and rehabilitation.

The suggestion has also been made, in several quarters, that an arrangement somewhat resembling a departmental setup could be effected in the states with fewer than three institutions by the appointment of the superintendent of one of them as coördinator and supervisor of the whole program, with responsibility for the handling and clearance of interstate affairs. A separate over-all department, it is objected in some of these states, would be superfluous as well as cumbersome, and it would be difficult to get an adequate and attractive salary for the commissioner of the department. We think that the question of the most desirable arrangement in such states may be left for a while to trial and demonstration by the states as experimental laboratories in governmental administration.

It is interesting to note, by the way, that size of population bears no direct relation to a state's having or not having a separate, coördinate department of mental health. While two of the states with such a department have populations of 7,000,000 or over, four of the states without a department have populations in excess of that figure. While four of the states with a department have populations of less than 3,000,000, 11 states without a department have populations of more than 3,000,000. Three-fourths of all the states have three or more mental institutions each; there are separate, coördinate departments in only 10. The total number of mental institutions in the four department states having the largest number of such institutions is approximately 65, while four states without departments have nearly as many.

Concerning the Commissionership.—The qualifications of the commissioner or director of a mental-health department should be stated in the law. They should certainly be as high, and of the same kind, as those of a hospital superintendent. We suggest:

> He shall have graduated from an approved medical school, and have served a general medical internship; he shall also have had three years of psychiatric training in an approved residency, and shall have had at least two years of additional experience in the practice of intramural or extramural psychiatry, or both. However, he shall have had not less than five years of experience in a mental hospital. Of these five years not less than three shall have been in a position involving administrative responsi-

bilities in a large mental hospital or institution, except that one of these three years of administrative experience may have been in a state or federal department that administers a system of mental institutions or clinics or both.

In the case of persons who entered the field of psychiatry prior to the formalization of professional training, equivalents for the above requirements should be recognized. It may be observed that the foregoing standards, except those pertaining to five years of experience in administrative work, are approximately the same as would make a person eligible for election as a fellow of the American Psychiatric Association or for examination by the American Board of Psychiatry and Neurology for certification as a diplomate of the board.

Since these suggested standards were formulated, the American Psychiatric Association, with the approval of its council, has established a committee on certification of mental-hospital administrators. Admittance to examination by this committee depends both on psychiatric training and on experience in mental-hospital administration. All applicants must be fellows of the association and must have had at least three years' administrative experience in the mental-hospital field; these are minimum requirements for examination, other training and experience being considered before certification. A further requirement, in the case of a psychiatrist who graduated from a recognized medical school after June 30, 1947, is that in addition to the three years' practical experience, he shall have had at least "one academic year of formal training, or its equivalent, in the various aspects of mental-hospital administration of a kind and quality acceptable to the committee." Graduates prior to June 30, 1938, who are currently mental-hospital administrators or assistant administrators and fellows of the association, may be certified without examination upon presentation of satisfactory credentials.

Comment may be made on the present paucity of opportunities for academic work in psychiatric administration. Medical schools do not provide such training for the specialty of administering psychiatric services. Schools of hospital administration do exist, but these are intended primarily for lay administrators of general hospitals. The administrative problems of general hospitals and of mental hospitals

are quite different in character. They differ with respect to size of operation, considering not only individual hospitals, but multiple systems; the number of chronic and bed-ridden patients; the feeding problem; the business of budgeting in relation to governmental requirements and procedures; and the matter of clothing purchase, and the procurement of other supplies; not to mention the special problems of legal responsibility, civil rights, and release of patients; also personnel problems, community relations, administrative methods and techniques. Adaptation or expansion of curricula in schools that now offer training in hospital or health administration seems to be indicated, so as to include the psychiatric aspects of administration. When we say "aspects," however, we do not mean to imply that in mental-hospital administration, as such, any sharp distinction can be drawn between its psychiatric and its non-psychiatric aspects. They are one and inseparable, parts of a single whole.

Why a psychiatrist as state commissioner? Because this is a psychiatric job. The psychiatrist, as administrator, remains a psychiatrist, only he practices his psychiatry through administration instead of treating individual patients. As the superintendent of the hospital is the captain of his team, so the commissioner heads a team of teams. The team in each case consists of other than psychiatrists, but it is still a therapeutic team, and the leadership can be fully exercised only by a man skilled in the art and science of caring for and treating mental patients.

William H. Newman, in *Administrative Action,*[1] defines administration as "the guidance, leadership and control of the efforts of a group of individuals toward some common goal," and says, "The man who has both personal experience with the operations and administrative skill has a considerable advantage."

In the field of education there is a feeling on the part of college and university faculties that experience in teaching and other educational matters is essential for effective service as administrator. No outsider can fully understand the basic problems and value systems and hence cannot function as well as one whose primary training and interest are in the profession.

[1] *Op. cit.*

The assertion has frequently been made that not all psychiatrists are good at administration. Quite correct. That is another thing, however, from saying that all psychiatrists are not good administrators. Which is worse than bad grammar. At any rate, the idea has been advanced that a good psychiatric clinician makes the best psychiatric administrator, partly because of his understanding of and sympathy with mental patients, and that a research attitude with experience may be an asset. The post of state commissioner, we submit, is one that calls not for ordinary qualifications, but for a person rarely and variously gifted. No doubt this is a large order, and difficult to fill.

Why not a "lay" administrator? True, administration is itself a professional job. There are said to be professional administrators who can administer almost anything under the sun, ably and efficiently. Yet a strong bias persists in favor of the administrator who knows what he is administering and cares deeply about it. General hospitals, a common argument runs, have lay administrators, so why not mental hospitals and hospital systems? The fact is that the parallelism has been greatly exaggerated. Very little parallelism exists between general and mental hospitals in the relation of the administrator to the medical staff, the medical staff to the patients, and the patients to the hospial. A patient who enters a general hospital has chosen his physician; the doctor or patient chooses the hospital, while the care and treatment of the patient continue to be directed by his own doctor. The function of the lay administrator of a general hospital is to see that facilities, equipment, and supplies are provided under the supervision of the chief of medical staff. He does not run the hospital. Such relationships do not exist in public mental hospitals, so the functions of administration are different from those of private, general hospitals. A business administrator in a mental hospital or a mental-hospital system should be subordinate to the psychiatric administrator, since business is an adjunct to the main purpose of care and treatment of patients, not vice versa. It cannot be assumed that what is good from a business standpoint is always best for the patients.

Legally stated qualifications of a professional character for commissioner or director of a state department of mental

health range from none at all in at least two states to the requirement in one state that he shall be a physician and a diplomate in psychiatry of the American Board of Psychiatry and Neurology, with at least five years' experience on the resident administrative staff of a state or federal hospital for mental disease (or any equivalent organization) or at least four years of such experience plus at least one year's experience in the department controlling such hospital. Requirements in other states are more general—*e.g.*, the commissioner shall be a doctor of medicine, licensed to practice in the state, with a broad experience in psychiatry and hospital administration; or he shall be experienced in psychiatry, in the administration of mental institutions, and in the care and treatment of persons of unsound mind. In another state, the director of the department may be either (1) a physician with specified experience (covering ten years) in the practice of psychiatry and the administration of mental hospitals and mental-health programs; or (2) an administrator with at least ten years' experience in the administration of mental hospitals and mental-health programs.

A similarly wide range of statutory qualifications is found with respect to the head of a division concerned with mental hospitals in a department of wide, inclusive scope. They may be practically non-existent, or they may extend, as in one case, to the requirement that the person appointed be a diplomate of the American Board, with not less than five years' experience in a responsible position involving hospital administrative duties; or, as in another case—in which a division of mental health in charge of hospitals has lately been established in the public-health department—that he shall have had ten years of experience in psychiatry and the treatment of the mentally ill, and sufficient training and experience to be eligible for board examinations, no mention being made of administrative training or experience.

In a few states the divisional head is under civil service, classified or unclassified. These various provisions of law, as to the qualifications of departmental and divisional heads for mental-hospital administration, are cited merely to show the utter lack of uniform standards around the country, as to fitness for the professional task of administering mental-hospital programs at the state level.

A prime qualification for a commissioner of mental health —one that is difficult to put into the language of statutory requirements—is that of leadership. This means not only staff leadership, but community leadership. In the general literature of administration, it is agreed that any top administrator of any organization must be both an educator and a leader. The educational function is associated with leadership, and both have to do not only with staff and employees, but with the community served. Who better than an experienced psychiatrist could perform this dual function of education and leadership, interpreting the aims and methods of the state's psychiatric services, for which his organization exists? Providing, of course, that besides his professional knowledge he has the *qualities* for staff and community leadership.

The leadership rôle of the administrator is emphasized by Ordway Tead in *The Art of Administration.*[1] The wise leader "will be concerned that the aims of his organization are of such a character that they can truly win the loyalty of those involved . . . He will be concerned to assure that people are 'getting a kick' out of being at work and out of the work itself . . . He will be concerned that people get a sense of belonging, of being wanted, of some security of status and some approval, within and through the activities of the organization . . . He will also be concerned that appeals are invoked beyond those of immediate self-interest. In wartime, for example, the power of a wider appeal was shown to be great. . . . In other times, he has the more difficult task of relating the enterprise to a larger social good, deriving from its productive utility or service. . . . People find deep satisfactions in being 'caught up' into the summons of a large cause."

"Nothing," says Tead, "is left to chance in the effort to inculcate in the individual the significance of his affiliation and the high seriousness of his coming to share in the pursuit of a common objective. For each new member to know what the organization seeks and why, how and where he shares in its efforts and benefits, is an immediate and continuing concern."

Some of this is undoubtedly what is called personnel work, but what cannot be delegated is the *leadership* of personnel.

[1] New York: McGraw-Hill, 1951.

A Hoover Task Force, in a report on "Departmental Management in Federal Administration,"[1] likewise stresses the point that a major task of a department or agency head is "to serve as the administrative leader of the agency to which he is assigned. . . . He must build a sense of loyalty to a common purpose or a general goal for the agency as a whole. . . . He must provide a positive sense of leadership for the department." Obviously, it is only by some person, an individual, that leadership in this sense can be exercised; and just as obviously, it is important to choose the right person for leader.

While the heads of subdivisions of an organization may and should lead those under their direction, the head of a mental-hygiene division within a department is likely to be somewhat handicapped in performing the function and rôle of leadership. Where, in the conduct of the mental-hospital program, there is overlapping and conflicting responsibility or authority and consequent confusion as to who runs it, divided allegiance results. For instance, in a number of states with either a department or a division of mental health or hygiene, the head of the department or division does not appoint his own hospital superintendents, if they can be called his own. Subordinates cannot serve two masters or follow two leaders, which is a situation not at all conducive to the exercise of true leadership.

A similar handicap to the exercise of community leadership is found where the mental-health director or commissioner occupies an inferior rôle in a departmental setup. He must guard against seeming to be too big for his boots, too independent. As we have suggested elsewhere, one of the reasons for choosing a psychiatric physician for commissioner of mental health, at either the departmental or the divisional level, is that the medical heads of the hospital system will more readily accept the suggestions and decisions of a fellow practitioner than those of a layman. There is likely to be more willing and dynamic team play. Several times on our field visits, however, we encountered instances of organizational setups in which the psychiatric chief at the state level had displayed all the best qualities of staff and community leader-

[1] Washington, D. C.: Government Printing Office, 1949.

ship, but yet could get nowhere because of the restrictions, denials, interferences of officials either above or below him in rank.

It is appropriate to point out here that a departmental or divisional commissioner of mental health, especially in the early years of the creation of such a department or division, deals with hospitals that have enjoyed pretty complete autonomy. The tendency in these hospitals is against the relinquishment of sovereignty, and that makes things difficult, but especially for the lay administrator. It may happen that psychiatrists entrenched as superintendents may object to a strong central authority and may be disposed to favor a layman in the chief administrator's post. We may add that board-of-control setups do not favor the kind of leadership required as a function of administration, since they usually lack any technically qualified officer who is qualified for such leadership or authorized to exercise it.

Appointment and Tenure of Commissioners.—Methods of selecting and appointing a commissioner are likewise important. Heads of mental-health departments are appointed by the governor in eight of the 10 states that have such a department, though in one of them the commissioner is responsible to a board, not to the governor; in the other two states they are appointed by a board. In several instances that have come to our notice, the governor has first appointed an *ad hoc* committee of citizens (professionals in psychiatry or in psychiatry and related fields) to help him in choosing a suitable person to fill a vacancy in the commissionership. This nonstatutory procedure speaks well for the interest and intelligence of the governor and his own sense of responsibility. The committee submits names and recommendations after a canvass of available or possibly available candidates suitably qualified.

In several states, again, the advisory board is charged with the duty of suggesting or recommending names for consideration by the governor, the details of the procedure varying among the states that have adopted it. This procedure, too, may be desirable, depending somewhat on the composition of the advisory board and partly on how much there is an element of compulsion limiting the governor's freedom

of choice. In one state, the governor appoints with the approval of a professional *ex-officio* board.

It may be noted that any citizen or citizen group has perfect liberty to suggest names to the governor, whether asked to do so or not. The kind of commissioner he selects is their business, and he is their governor. It is quite possible and probable that some protection against bad political appointments is afforded by a statement of very stiff professional requirements in the law, narrowing the field of choice to men who have devoted ten or more years to a medical-psychiatric career. Such men may not be entirely above politics, good or bad, but certainly they are not so likely as many others to be or to become political stooges. They have their professional standards. We repeat that what this country needs is a supply of "career men" in administrative psychiatry and a demand for them in attractive and satisfying jobs. The demand will help create the supply.

Of course it should not be necessary to have to protect state psychiatric services against a bad—*i.e.,* an indifferent or unenlightened—governor in mental-hospital and mental-health affairs. In our system of state government, the governor *is* the chief executive of all services to the people. The governor is, in constitutional theory—and increasingly in practice under reorganized systems of government—the chief administrative officer of the state. He is responsible to the people, while the department heads are responsible to the governor. We cannot have better governors than the people elect.

The requirement of senate approval for appointments made by the governor originated apparently as a part of the system of checks and balances in which, Macdonald says,[1] "the American people have placed—or misplaced—so much confidence." It is also based partly on "the fear that the governor may make wrong appointments, and the hope that the members of the senate will keep him on the straight and narrow path, and also the path of wisdom." Unfortunately "politics," in quotation marks, is involved. "Faced with the necessity of winning support for his legislative program, many a governor has purchased that support by appointing to office the friends of influential senators. Thus members of

[1] *Op. cit.*

the senate have come to regard the selection of administrative officers as one of their inalienable rights; they unite in open hostility to the occasional governor who dares to flout their wishes by appointing men to office solely on the basis of merit. This vicious arrangement should be destroyed." It has not been.

In the past there have been very few specific instances of required senate approval of appointments to the commissionership of mental health or hygiene (where such a department existed). There are none at present, according to our information, a fact that shows some advance in regard for administrative principles; but it is also true that such approval is statutorily demanded in the appointment of heads of general departments that have authority over mental institutions and of members of boards that have administrative powers and duties in this area. But we do wish to warn citizens and legislators against this practice of senate approval of guberatorial appointments of men responsible for state psychiatric services.

Current patterns of legal tenure of a mental-health commissioner raise questions of desirable practice. In eight of the 10 states that have a mental-health department, the commissioner is appointed by the governor—in three, at the governor's pleasure; in three, for a term continuous with the governor's four-year term; in one, for a term of six years, while the governor's is two years; in one, for an indefinite term, to continue in office unless and until removed by the governor for incompetency or misconduct.

We have already expressed our belief that the commissioner of a mental-health department should be appointed by the governor, to whom he would be responsible. This not only recognizes the governor's rôle in state government as the chief executive of the state; it also fastens on him, quite properly, a more direct, though not a greater, responsibility for the efficient conduct of the work of the department—the department being the agent of the state in performing that work. Moreover—and the importance of this fact should not be minimized—the relations thus established between governor and commissioner enable the governor to keep more closely cognizant of that work and more keenly aware of his own responsibility. Where the relations between the two are in-

direct and distant, through a board or department head to whom the mental-health commissioner or director is subordinate, their contacts are few and at second-hand, to the disadvantage of both.

How long the commissioner's term should be is a question on which opinion varies widely among our consultants. If the commissioner is to be "the governor's man," a member of his official *family*, if not his official *cabinet*, then it would seem as if his term should be at the governor's pleasure or coterminous with the governor's term. Opinion was unanimous, however, that it should not be limited to two years, the length of the governor's term in 20 states. Two years does not afford much time for a commissioner to get going and accomplish things. Again, why should the mental-health commissioner's term be dependent on that of the governor? Why should it not overlap? His is a professional task, so why make his tenure dependent in any way on political considerations? Governors may come and governors may go, but the professional task remains. The efficient performance of that task is an asset to any governor, if he can but see it. Another reason for electing the right kind of governor, who can work with non-political professionals.

But if the governor is to have top responsibility for the state's administrative services, should it not be accompanied by the power of removal of his department heads? Macdonald quotes A. E. Buck, who, in a pamphlet on "Administrative Consolidation in State Governments," lists among his standards of organization: Each department should be headed by a single officer appointed and removable by the governor.

This removability would seem to relate rather closely to the question of responsibility. Most of our consultants agreed that the tenure of mental-health commissioners should be "protected," and not subject to whim or caprice; that they should be employed for merit, and never dismissed from their posts for any political, non-professional reason. It was suggested that dismissals be justified only by lack of professional competence, neglect of duty, or immoral behavior, and then only after a legally prescribed procedure of appeal and hearing, reaching even into the state courts, as is true in some states with regard to lesser officials. One proposal was that a commissioner's tenure should become permanent after a cer-

tain number of years of successful performance in the job. All of which sounds complicated and somewhat inconsistent with the idea of a mental-health commissioner as the "governor's man."

Some students and practitioners of psychiatric administration seek to reconcile this idea with that of the commissioner as a more or less independent professional by suggesting that while the department head might be appointed and removable by the governor, and might even be a layman, there should be an associate or deputy commissioner with protected tenure under statute or civil service who could provide continuity of program. That raises still further questions of divided authority between the two, and of contact between the professional deputy (reduced to a subordinate position) and the governor.

We still adhere to our belief in these essentials: (1) a psychiatrically and technically qualified commissioner of mental hygiene, (2) appointed by and responsible to the governor, and (3) removable (during the term for which he has been appointed) only for proven cause of a non-political and non-personal nature. It can be left to the individual states to fill in the details.

The Central-Office Staff.—The tasks of the administrator of a large and ramifying enterprise are often beyond the capacity of any single individual. One of the essentials of good governmental administration, as stated by a Task Force of the Hoover Commission, is that the executive officer of a major agency responsible to the President shall have adequate staff assistance to assemble the facts on which he bases his decisions and policies and to help in seeing that they are carried into effect. This principle applies equally well to state government and the chief lieutenants of the governor. It applies in particular to the commissioner of mental health. The Joint Senate and House Committee to Review the Maryland Mental Health Program reported (1949): "To enable him to execute his duties successfully, the Commissioner should have the assistance of expert professional and administrative personnel at the State level."

Such a staff of specialists not only gives technical information and counsel to the commissioner, serving as a sort of cabinet, but also relieves him of the burden of detail imposed

by his manifold responsibilities and frees his time for the tasks of his generalist's job, which is a specialist's, too. The staff share in his work through division of labor, contributing their own knowledge and techniques to the common cooperative enterprise, and extend his reach in the way of advisory and practical aid to the hospital personnel.

Among the mental-health departments around the country, the central-office staff varies widely in number, and quite as strikingly in its composition as representing specialized functions and the titles borne by staff assistants. Uniformity in these matters is not needful or important. What *is* important is the idea of a central-office staff so organized as to provide the needful services to the commissioner and department. Variation of species and adaptation to environment play their part in the development and evolution of state psychiatric services.

We find on the central staff such positions as: administrator (or assistant administrator) for business affairs; director of statistics (which is a tool of administration); and specialists in psychiatric nursing, psychiatric social work, occupational therapy, nutrition and food service, clinical psychology, clinic and community services, and educational publicity. This is not a list of positions found in any particular central-office staff, nor is it intended as a recommended minimum or complete list, though all the functions indicated should undoubtedly be included. The special services should be there, but might be differently organized and titled. We find in various states such titles as farm consultant or coördinator, and directors or supervisors of personnel, in-service training, volunteer services, rehabilitation, libraries, recreational therapy, child guidance, and so on.

Further comment may be offered. Just as we have autonomous administration of hospitals as little principalities, so we also have departments that want to be free of complications with other departments of the state. This raises the question whether the operations of a mental-hospital farm consultant would not be an appropriate responsibility of a department of agriculture rather than of a special consultant within the mental-health department. On our field visits we encountered these opinions about mental-hospital farms:

(1) that often they are financially more of a liability than an asset to the hospitals; and (2) that anyway their chief value is therapeutic, only they are not usually and actually run that way, the use of patients on the farms being dictated by other than therapeutic considerations. The issue seems to lie between the financial and the therapeutic value of hospital farms. It was suggested that more research should be done on both aspects of this problem, with a view to the separation or at least reconciliation at these two discordant approaches—farming for profit and farming for therapy. Hospital farms seem to be a legacy from the old days of almshouses and poor farms. Should not farming for profit and farming for the treatment of patients be regarded as two separate things, and not confused? Or at least be conjoined?

Again, it may be noted that on the above lists of central-office personnel, no mention is made of a special assistant for the care and treatment of the mentally deficient. Assuredly, the care and treatment of the mentally deficient is a special problem, differing in many respects from that of the care and treatment of the mentally ill. Some states do have on the central-office staff a specialist in mental deficiency. In one state the commissioner has lately created the position of supervisor of education, its incumbent (not a psychiatrist) being charged with the "further development of the academic program in state schools for mental defectives." This is an interesting step in recognition of the rôle of the professional expert in "special education" of the mentally retarded in institutions. While a department of mental health should doubtless embrace the mentally deficient as well as the mentally ill, the problems of the institutionalized mentally deficient are more than medical and psychiatric and call for the specialized assistance of an educator at the state level of supervision.

Note may be taken of the administrative principle enunciated in the report of the Maryland Joint Committee of 1951:

> "The Committee wishes to emphasize again, as did the 1949 Committee, that the staff positions in the central office should perform only functions of technical assistance to the Commissioner and to officers at the hospital level. The 'chain of command' must be maintained through the Commissioner's office to the five Superintendents, who in turn will give direct supervision to their subordinates. To permit lines of authority to

develop between the staff officers at the central office and their corresponding officers in the institutions would merely create a new form of confusion that might have as disastrous results as the complete lack of direction criticized by the 1949 Committee."

Should not the commissioner or director of a division in a department have the same sort of specialized assistance as the commissioner of a department? To what extent can he depend on personnel outside of this division to furnish such desirable or necessary aid? The duties and qualifications of a nursing, social-work, or statistical chief of a welfare department may not be sufficiently geared to the special needs of the mental-hygiene division within the department. The central-office staff of a basket department is used for all purposes, but the requirement for the mental-hygiene program is nurses, social workers, and other personnel who are psychiatrically trained. It should also be borne in mind that a mental-hygiene division may, and in some states does, have as large a task to perform as a mental-hygiene department—sometimes a larger task in terms of state population and number and population of mental institutions.

Statistics as a Program Aid.—The many jokes about statistics usually stem from misconceptions of their true nature. The popular mind has a tendency to look upon and accept almost any compilation of figures as "statistics," and to make no distinction between them and data properly gathered and presented for specifically useful purposes. "Statistics show" is a familiar phrase, but it often does not mean anything. But, rightly used, statistics are an essential tool of administration and an important means of public information. In distinction from figures, it is the function of statistics to be meaningful, to explain by analysis and comparison, to furnish clues looking toward further explanation, and to serve as a guide in the making of plans.

The Hoover Task Force *Report on Statistical Agencies of the Federal Government*,[1] referring to the scope and purposes of the activities of these agencies, says: "Long-range policies and day-to-day decisions on public and private issues are based on the intelligence thus provided." The report gives numerous examples of the use of statistical information by

[1] Washington, D. C.: Government Printing Office, 1949.

all branches of the government—executive, legislative, and judicial—and by farmers, business men, labor and management, school authorities, social scientists, and ordinary citizens. In short, "Over a wide range of activities, governmental and private, statistics are a major instrument in studying the results of past operations and estimating the probable effects of contemplated operations. They are the foundations of an informed public opinion in a complex society."

The point of these quotations is that they apply to the use and value of statistics in the administration of state mental-hospital and health programs, institutional and non-institutional, including clinics, and ranging from business to psychiatric policies and practices. Yet comparatively few states have the requisite personnel and facilities to utilize to the full this invaluable adjunct to good administration in the mental-hospital and mental-health field. Agencies of control and management, in many states, so far as mental-hospital statistics are concerned, are limited largely or almost entirely to mere bookkeeping and routine tabulations in annual reports. Most of them are unable to furnish so simple and desirable a thing as an analysis of the composition of patient population as of a given date, even the end of a fiscal year, without laborious and time-consuming effort. Some can do so readily, with their punch-card systems and sorting machines.

The functions of a statistician or a statistical bureau in a state setup go far beyond the customary regular, year-by-year collection and reporting of uniform statistics for the state agency and the federal government. They relate directly, in many ways, to the administrative process. Studies of the make-up and geographical distribution of the general population, studies of admissions and other factors in the movement of hospital population, and studies of trends both in the general and in the hospital population, certainly throw light on such problems of planning as the need and location of new hospital facilities, and on the particular purposes that these new facilities should serve. Statistics are an essential aid in the intelligent preparation of budgets. They permit comparison of hospitals within a state system, and afford clues to the causes of difference in costs of operation as well as in rates of discharge, recovery, death, and so on.

A qualified statistician—or preferably a biometrician—belongs on the assistant staff of a state commissioner of mental health and hospitals; or, at any rate, the services of such a specialist should be available to the administrative agency, whatever it may be. The problems of mental-health administration are complicated and to a large extent *sui generis*. Especially to be noted are statistical investigations of the results of different forms of care—family care, trial visit, and so on—and of various methods of treatment, such as shock therapies.

Other helpful studies are those of the hospital histories of mental patients, by age, sex, and psychosis, and follow-up studies of released and discharged patients to see how they readjust to family and community life. All of which contribute to decisions as to what administrative and treatment methods should be continued or extended or dropped.

Then there are studies of broader social significance, such as the effects of an aging general population on mental disability and consequent hospitalization; the relation of urbanization and changing mores to the occurrence of mental disorder and hospitalization; the relation of occupation and economic status to mental health and disease; and the incidence and expectation of mental illness, with their implications for its prevention and early treatment. Statistics are both informational and educational.

Notice must be taken of the Model Reporting Area, as constituted under sponsorship of the National Institute of Mental Health, of the Public Health Service. About a dozen states have already joined this pilot project in mental-hygiene statistics. Standards of admission for a state that wishes to join the Model Reporting Area include (1) a central reporting system; (2) professional statistical personnel; and (3) adoption of the uniform definitions and preparation of the minimum number of basic tabulations as recommended by the Model Area and the National Institute of Mental Health.

Undoubtedly uniform definitions are essential to uniform statistics. We concur heartily in the recommendation of the Council of State Governments, in its recent report, *Training and Research in State Mental Health Programs*[1]: "All States

[1] Chicago: Council of State Governments, 1953.

should coöperate with the Public Health Service in the adoption of uniform terminology and statistical reporting procedures in the field of mental health." We might add something to the effect that some of the smaller states, which may not be able to get or to afford independently separate professional statistical personnel and facilities, might join together to provide statistical research facilities and services, along the lines of the Model Reporting Area.

While statistical research is itself imperative, it is an invaluable adjunct of clinical research. We refer the reader to the above mentioned report of the Council of State Governments for findings and recommendations on both training and research.

Public Health and Mental Health.—Federal grants to the states in aid of "mental-health programs" conducted outside of mental hospitals or institutions have greatly stimulated the development and expansion of such programs. In a given state they are administered by a designated "mental-health authority." By instruction of Congress, in the National Mental Health Act of 1946, the agency to be so designated is that in charge of public health, unless some other has definite responsibility for the state's mental-health program, if any, outside of the institutions. In more than half the states, the mental-health authority is the board or department of public health; in fewer than half, the agency that administers the mental hospitals.

If all this has a little the appearance of robbing Peter to pay Paul, the question may be raised, Has Peter really been robbed of anything? Does the preference for the state health department in the designation of a mental-health authority mean that the agency in charge of mental hospitals has been discriminated against? Let us look at the record:

In many instances the agency in charge of mental hospitals had not been, and still may not be, very active in the provision of extra-institutional, community services. Such inaction may be its own fault and shortcoming, tracing back to absence of legislative support and this in part to the type of administrative setup and the consequent kind of direction and leadership. Public-health departments, generally, had been even less active, so far as mental health is concerned, before the

establishment of federal grants-in-aid. But here were these health departments, ready to hand in all states (and willing in most of them), possessing organizational advantages for the purposes and responsibilities of federal-state administration involving community services. In brief summary, nevertheless, the state-hospital agency has not been deprived of the opportunity to develop extramural services, or debarred from obtaining funds through the mental-health authority (if located elsewhere in the state government) for extramural programs, or prevented from qualifying for designation as the mental-health authority.

Since January of 1950—that is, in the last three years of the period since the inauguration of federal grants-in-aid for mental-health programs outside of institutions—the number of states in which the health department or board is the designated mental-health authority has decreased by three, while the number of states in which the mental-hospital authority and the mental-health authority are the same has increased by four. As of late 1953, the mental-health authority is located as follows:

In health board or department	26 states
In department of health and welfare	2 "
In mental-hospital agency	21 "
In state psychopathic hospitals	1 state

The total here is 50 states because Missouri and Indiana are counted twice—Missouri, because the mental-health authority is in the department of health and welfare, the hospitals in one division and the mental-health program in another; Indiana, because in that state, lately, the mental institutions have been placed in the health department, along with the mental-health program. Since January 1, 1950, the number of states in which the mental-health and the mental-hospital authority are the same has risen from 17 to 21. Five states actually joined this category, but one was lost to the list when Vermont took the mental institutions out of their brief sojourn in the health department. The mental-hospital agency is most likely to be the mental-health authority if it is a department of mental health or hygiene (as in 70 per cent of the cases); less likely if a general department of welfare or institutions (55 per cent); and unlikely if a managing board or commission (under 15 per cent).

The events of recent years, however, have tended to draw a sharp line of demarcation between mental-health programs and mental-hospital programs, with mental health on one side and mental illness on the other, quite separate. By many of our consultants, such a division is regarded as unfortunate. While we have not attempted to evaluate the mental-health programs of health departments, most of them, naturally and properly enough, devote their special attention to what are called "educational and preventive services," and with few exceptions shy away from having much, if anything, to do with the treatment of mental illness, except in the way of referring serious cases to other agencies. At any rate, most public-health departments are frankly indisposed to take over the administration of mental institutions. Vermont, it is true, had them in the health department for two years under conditions that precluded any fair trial of this unique arrangement, and Indiana has now put them under a mental-health division of the public-health department. Parenthetically, this Indiana division is legally clothed with a large degree of independence.

A leader in the public-health field, the late Dr. Joseph W. Mountin, has said (in the *American Journal of Public Health*, February, 1940) that "it seems doubtful if health departments can attain any stature in mental hygiene without first taking charge of the mental institutions." One of the objections on the part of health departments to the joining of mental institutions to the public-health department is that this would increase the department's budget four, five, or more times, so that legislators might react unfavorably to further increases in the larger budget. Another is that it would tend to subordinate and possibly weaken the regular and traditional public-health activities within the department. Still another objection, often heard, is that a program of positive mental health—and particularly that of child guidance—should be kept quite apart from connection with or connotations of mental illness and mental hospitals, because of the so-called stigma popularly attached to mental illness and hospitals. Apparently the idea is to avoid any suggestion of "guilt by association." However, one doubts if a policy of keeping mental health and mental illness in separate compartments helps to erase that stigma, or to advance the understanding of either.

Without intention of reflecting on the activities of public-health or other agencies in the promotion of mental health and the prevention of mental illness, we do deplore the lack in many states of extra-institutional community programs in this area as an integral and important part of the work of mental hospitals and mental-hospital systems. Mental health is their business outside as well as inside the hospitals. They have a proper and practical concern with the prevention of mental illness as well as its treatment—and their treatment function should not be confined within hospital walls. A more active participation by the hospitals and hospital doctors in the preventive effort would seem to us highly desirable—probably a good thing from the point of view both of prevention and of treatment, and good also for the hospital doctors, helping them to see their case problems whole.

Be that as it may, there is obviously a widespread and pressing need for a great expansion of hospital-sponsored, community-centered clinics, or field stations, not only for follow-up assistance of released patients, but for diagnosis, treatment, and counsel of all who may apply or be referred. Through these clinics, "educational and preventive" services should be rendered, thus making them really all-purpose clinics. Let the hospitals function in the communities, where the people are, as friend and helper of those in trouble, and not stand as some dread and distant enemy or appear as a last, desperate resort of the damned.

An Ounce of Prevention Not Enough.—Of course, nobody in his own right mind would wish to discourage or to disparage the effort to prevent mental illness, or the participation of many agencies, public and private, in this effort. Quite the contrary.

The fact that admissions to mental hospitals continue to increase faster than the general population, and that the hospital population shows a still higher rate of increase than first admissions, does not mean that preventive programs and measures are ineffective, though it could be wished that more knowledge, more precise, were available regarding the results obtained by the methods employed. Numerous factors play a part in the growth of hospital admissions and hospital population—including the greater willingness of people (for various reasons) to use the hospitals; the aging

of the general population (resulting in the presence of more persons in the age-groups in which the incidence of mental illness is highest); and the accumulation in hospitals of long-time cases (particularly those with schizophrenic psychoses).[1]

But the problem of preventing mental illness must not be confused with that of preventing hospitalization (often desirable); it is a problem of social and human welfare broader than that of overcrowded and costly hospitals.

The effort at prevention of mental illness follows no single form or formula. Writers distinguish between primary and secondary prevention, and subdivide these categories, primary prevention including various ways and means of prophylactic promotion and building of mental health, and secondary prevention the early treatment of mild disorders in the hope that they will not proceed to more serious difficulties. With regard to child-guidance clinics, as Dr. Ernest M. Gruenberg says,[2] "it is presumed that the provision of early diagnostic and therapeutic psychiatric services in a disturbed child's life will prevent further complications and later neurosis or psychosis." He adds that "whether this is the case, is not known." But whatever the "preventive" value of these clinics, it "cannot be doubted that they meet an immediate problem of children, of their parents, and of their schools." The fact is that much of the prevention of mental illness is not purposely designed as prevention. Mental health may be sought as a good in itself, and conceived more broadly than the early detection and treatment of mental disorders.

Nor is prevention wholly or always psychiatric—far from it. Early treatment, like later treatment, is essentially psychiatric, but the removal of adverse conditions and noxious influences that contribute to mental ill-health lies more often in other fields. There conditions and influences arise before the need of treatment is apparent, in all sorts of situations and relationships and events—in home, school, office, store,

[1] About 55 per cent of schizophrenic patients in the New York civil state hospitals have been there ten years or longer. The average stay of all patients in these hospitals since last admission is 7.2 years. The average stay in the general hospitals of the country is ten days.

[2] In the Mental Health Number of the *Annals of the Academy of Political Science*, March, 1953.

factory, and community—before they come into the psychiatrist's professional view. Technically speaking, prevention calls on a number of quite different disciplines. For example, the prevention of general paresis calls upon the syphilologist; of pellagrous psychoses, upon the nutritionist; and of psychoses due to brain injuries, on the safety consultant. The psychiatrist, however, through his knowledge of cases and their etiology, is in a position to point to the places where prevention must be carried out, but often must then pass the ball on to others in other fields of work.

In short, the preventive attack on mental illness must be made concertedly on a wide front. There are so many and such varied kinds of prevention that it can hardly be regarded as the monopolistic enterprise of any one agency. It requires the constant and close coöperation of many agencies, public and private. Such departments of state government as those of public health, education, welfare, correction, and labor and industry, have their own responsibilities and their own opportunities in this area, through their relation to people and communities. Some of them have mental-health programs, whether or not these are called "preventive," and whether or not psychiatrists are in charge or on the staff. These special programs have their undoubted place and value, but equally, if not more, important is the education of the staffs of public health and other departments in the principles of mental hygiene, so that they can contribute toward prevention by applying this knowledge in their everyday work and contact with the people whom they serve.

We believe that primary responsibility for the development of mental-health and preventive programs should be centered, at the state level, in a department that administers the mental institutions. There should be definite organizational provision for inter-agency coördination, beyond merely casual coöperation, in the sharing of the larger task. It is desirable that representatives of various departments meet regularly or frequently to consider common or interrelated problems, and ways of meeting them, under the chairmanship of the commissioner of mental health; likewise, that the commissioner of mental health participate in groups chairmaned by the head of another department, when the task or problem lies immediately in the field of that department.

Examples of inter-agency coöperation range from informal, but businesslike get-togethers of chief officials at luncheon, through the loan or sharing of specialist personnel, to the legally established Mental Health Commission in New York, consisting of five department heads, which is charged with the development of a comprehensive state-wide program for the prevention and treatment of mental and emotional illness, and which carries on a variety of training, research, and community-service projects in demonstration of such a program.

In too many states, however, we have found too much evidence of "departmentalitis," or attitudes of excessive self-sufficiency, and have observed a spirit like that of the warning sign, "Any trespassing on these premises will be duly resented."

Requisite to a well-integrated mental-health and preventive program is intensive, comprehensive research into every phase of the problem, along with training facilities for all groups of psychiatric personnel. Prevention of mental illness due to brain injuries and infections or to nutritional deficiencies, where the complete progression of the disease process from cause to effect is clearly understood, does not apply to the greatest number of mentally ill persons or of hospital patients. Knowledge of the results of early diagnosis and prompt treatment in cases of so-called psychogenic psychoses is yet far from complete, and there is still some controversy as to whether these disorders are either psychogenic or preventable. So what about the schizophrenic psychoses, for example, which account for 30 per cent of first admissions to the civil state hospitals of New York, and nearly 60 per cent of the total number of patients resident in these hospitals? Scientific research and investigation into the causative factors, not only in schizophrenic and manic-depressive, but in arteriosclerotic and senile psychoses (where organic factors are obvious), must be diligently pressed, and should include not only origins and etiology, but methods and results of treatment as well, if the mounting rate of hospital admissions and population is to be arrested, and if the social, economic, and human costs of mental illness are to be reduced.

This research is not wholly psychiatric, of course, since it

must employ various medical, biological, and social disciplines, but it is the imperative necessity and dire need of psychiatric administration to promote and supply it, though not exclusively its obligation or that of the psychiatrist, who must play a strategic part in the total push.

Research costs money, but business and industry think it pays. As it is, only two cents of every dollar spent on medical research in this country are available for research in mental illness, though mentally ill patients occupy over half of the nation's hospital beds, and the direct expense for mental illness in 1952 was more than a billion dollars, or one-third of the nation's bill for medical care. Seven times as much money per patient is spent for basic studies upon the cause, prevention, and treatment of each of the diseases of tuberculosis, cancer, and polio as for research in mental illness and its prevention.

Research activities in a state hospital or hospital system should be coördinated under a research director, so that problems will be attacked and projects conducted in a purposefully planned and interrelated, correlated way. But research in mental health is far more than a hospital affair; it involves many agencies. This is partly because mental illness is not a single or specific disease, but comprises a large number of disease entities, each requiring its own research—arteriosclerosis, for example. Linking research and training activities as essential to good mental-health administration, the Council of State Governments recommends the establishment in each state of a technical advisory committee, including representatives of the state-hospital system, institutions of higher education, and other private and public agencies, to assist the director of research and training in the coördination of activities in these fields. Mental-health research, with which we are here particularly concerned, needs a clearing-house.

Recent Legislation and Trends.—Indications of trend in recent legislation affecting administrative setups and systems have been unmistakably in the direction of improvement. They are not numerous, but they are significant of a growing recognition of sound principles applicable to the administration of state psychiatric services. On the whole, there seems to be little evidence of backward motion, while

in some of the states in which legislative changes have been made, these do not appear to have resulted in motion either backward or forward, to any remarkable extent. We wish to accent the positive gains, as a promise for the future. A few may be briefly mentioned.

Since January 1, 1950, three states have established separate and coördinate departments of mental health (Kentucky, Tennessee, and Connecticut), bringing to 10 the total number of states with such departments. One state (Indiana) has dropped out of its dubious place in this category by setting up a strong division in its health department.

The Kentucky department was created from a division in the welfare department; that in Tennessee, out of a department of institutions. In Connecticut the three hospitals for the mentally ill and the Child Study and Treatment Home were brought together and the department designated as a single budgeting agency for these institutions. (Institutions for the mentally deficient are absent from the Kentucky and Connecticut departments.)

In Kentucky and in Tennessee the department has been designated as mental-health authority, thus bringing, with other additions, the number of states in which the mental-hospital authority is also the mental-health authority to a total of 22. In the three states with new departments the governor appoints the commissioner. In Kentucky the commissioner appoints his own superintendents; in Tennessee, he appoints them subject to the governor's approval; in Connecticut he nominates them, the appointments being made by the local boards, which are otherwise largely advisory, though formerly of the administrative type. Each of the three new departments is served by an advisory, not an administrative, board—a choice faced and deliberately made by the legislatures.

Mention may be made of the new administrative setup in South Carolina. Although not called a department, it has many characteristics of one. The state mental-health commission, with its director as executive officer, acting under a broad delegation of powers and duties, has responsibility for a unified, comprehensive mental-health program embracing institutions and clinics; it is the mental-health authority. Concerned exclusively with mental hospitals and health, it

administers a more comprehensive program than that of several so-called departments of mental health.

Kansas has strengthened its mental-hospital administration by establishing (under the board of social welfare) a new division of institutions, chiefly mental institutions, headed by a director who must meet high qualifications, stated in the law, of psychiatric training and administrative experience. He appoints the superintendents. The head of the new division of mental health in the Indiana department of public health is given "complete administrative control and authority" over the work of the division, and is the mental-health authority. The powers and duties of the old state council for mental health continue as advisory, and those of the local hospital boards of trustees have been transferred to the divisional commissioner. The latter has to meet high standards of qualification, stated in the law. The general assembly expressed its "desire that this office be held by a person qualified by experience to administer this division and that his term of office be limited only by his ability, proper performance of the duties of the office, and the provisions of the Constitution of Indiana." With the approval of the governor, by whom he can be removed "for cause," the commissioner appoints the superintendents.

These instances of recent legislation are not cited as a complete survey, but only as indicative of a noticeable trend toward specialized and competent administration of state psychiatric services. The methods of progression and its rates of speed may vary. The tortoise is slow, but it does move. One often gets the feeling that a bunch of firecrackers exploded behind it might help a little.

In Brief Summary.—There is a tremendous *job to be done* in this country in the care and treatment of the mentally ill, in the prevention of mental illness, and in the restoration of patients to community life. This job is largely up to the several states and so, largely, up to the citizens and voters of the states. If the job is to be efficiently and effectively done, its administration should in most states be entrusted to a separate, coördinate department of mental health. The department should be headed by a person specially qualified not only by psychiatric training and experience, but also by appropriate training and experience in administration. The work

of this department should embrace both institutional and extra-institutional programs and activities in close coöperation with public and private agencies in the state and in the local communities. The people have already demonstrated their capacity for the forwarding of "progress" in material and mechanical forms; it is their inescapable obligation to serve with equal enterprise and vision the values of the human mind and spirit. Ours cannot be a truly healthy nation until its citizens take as much concern for the mental as for the physical and social aspects of "one health." What can it profit a nation to conquer time and space, and grow rich, prosperous, and powerful, if its people have not the mental and emotional health which is the sign and safeguard of its greatness?

SOME SUGGESTIONS ON THE RÔLE OF THE CLERGYMAN IN COMMUNITY MENTAL HEALTH

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IT is the purpose of these comments to suggest briefly the ways in which the clergyman may help to promote mental health in the community, to assess the extent to which clergy are equipped to do this, and to consider what the mental-health movement can do to help more clergy make their full potential contribution.

A prefatory word is needed about the relevance of mental health to religion, to the churches, and, therefore, to the clergyman. If mental health is regarded as a wholly "outside" activity, as a good humanitarian cause, but without religious rootage, then it seems very likely that only a few of the clergy will work hard to promote it. But if it is in fact an enterprise that tries to fulfill aims that the church and religion also want to fulfill, then the attention, interest, and activity of a vastly larger number of clergy can be enlisted in this cause. I firmly believe the latter to be true.

We must admit, however, that, despite the best will in the world, those of us who have been involved in the organized mental-health movement have often talked and acted as if it were a thing in itself—as if, for example, the index of movement toward mental health in a community were the number of pamphlets labeled "mental health" going out from an agency entitled "mental health," and were not also and, indeed, more importantly, the mental-health principles in the schoolbooks, religious-education materials, books on child care, and so on, that are being intelligently used in the community.

I realize that there is no easy answer to this. We cannot do without organized mental-health bodies, and they must have a program and not just depend on the mental-health aspects of other programs. But somehow both sides of this must be kept clear. If they are not, then the clergyman will

tend to think of mental health as something extraneous, not as an inherent, inevitable, and vital aspect of his own religious aim and activity.

A few comments will now be made on the types of activity by the clergyman that are of especial significance for mental health in the community. This cannot be much more than a catalogue.

The Personal Ministry.—There is, first, the personal ministry to the individuals and families of the congregation. The clergyman is in on the regular crises of life, such as birth, death, vocational choice, marriage. He is usually in on the irregular crises, such as illness, severe misfortune and loss, and the various cataclysmic ills that flesh is heir to. If he has, in addition to his traditional religious resources, also absorbed the modern insights into the dynamics of personality and of personal counseling, he can be of inestimable value to his people and thus, indirectly, to community mental health. There is no doubt that this is his work, a basic aspect of his religious job. The only question is how well he understands it, and what resources of knowledge, skill, and personality—as well as of religion—he can call on to do it well rather than poorly.

We should not overlook the special personal ministry now being exercised by a growing number of clergymen as chaplains, in hospitals, in the armed forces, in prisons, and elsewhere. Wherever people are taken out of the home and parish situation, temporarily or permanently, it becomes increasingly difficult for the parish pastor to meet their religious needs. The approximate doubling of the number of clergymen giving full time to chaplaincy service over the past decade is not only an indication of the need, but also of the increasing recognition, by the churches and by the community, of the significance of continued ministry to persons in non-parish situations.

The Group Ministry.—As the principal leader of a specific church, the clergyman operates in large measure indirectly, through the numerous groups of the church—all the way from the Cradle Roll to the Golden Years Club. The potentialities for mental health in all such groups are very great, and every church has these groups. The question is: Can the clergyman, either directly or through his lay helpers,

make these group activities count in the genuine and full-bodied personal growth of the members, and thus in fact contribute to mental health, whether the phrase is ever mentioned or not?

Dr. Dallas Pratt has recently called our attention cogently to another aspect of this business of groups. If we really believe in mental health, he implies, then we will be concerned to try to see that every group or agency or institution is itself organized, administered, and defined in line with basic mental-health principles. Of what value would it be to the cause of mental health (or of religion either) if a minister presented a sermon on mental health, but laid it out in authoritarian fashion, and then moved like a pile driver to squelch every bit of realistic discussion about his views? As Pratt properly implies, the very constitution of a group is either mentally healthy or otherwise; and if we believe in mental health, we shall try to have one type of group rather than the other.

Not a few of the problems, and natural life crises, can be helped immeasurably not only by the ministry of pastoral care, but also by vital group activity. Group dynamics and group therapy are discovering, in the form of basic theoretical principles, the great resources that the churches have always used, though often without understanding what was taking place. Through his group as well as his personal ministry, the clergyman may also do much in terms of the possible early detection and prevention of mental ills, if he is also in intimate touch with the agencies of the community to which cases can properly be referred.

The Collective Church Ministry.—Our American religious life, especially in its Protestant manifestations, is organized under a multitude of headings unknown elsewhere in the world. We Protestants are mostly, although not wholly, ashamed of this; for in many instances, the divisions have represented honest differences of conviction which, according to mental-health principles, should be dealt with openly rather than repressed. We have learned a good deal in recent years of how they can be dealt with openly without producing division, and this ecumenical movement is growing.

Even in Protestantism, therefore, machinery and the proper will are being provided whereby the churches may do things collectively that were, in previous decades, done only

individually. The full significance of this is very great for many things, including mental health. In more than one state where progress in mental-hospital affairs has been threatened by some social or political circumstance, the churches have shown a power to testify to the human values in the situation that has aided in producing favorable results. I believe that every mental-health society should make a conscious attempt to win the support, not only of individual clergymen, but also of the central representative organizations and persons in each faith group. On many—though not all—matters of mental health, all the faith groups are equally positive. Their collective witness and help may take time to win. But in the long run, it is worth much more to community mental health than is the support of individual clerygmen, however, talented, concerned, or able.

The Ministry of Community Leadership.—From its very beginnings, clergymen have been active in the leadership of the mental-health movement. One guesses that there is hardly a society's board anywhere in the country that does not contain one or more clergymen. Whatever may be said about our ideas, education, or personality, we can usually talk with a certain mellifluousness, are useful in saying grace at annual meetings, and may help to cast an aura of respectability over proceedings whose radical character the discussants may be a little afraid lest the community discover. Whether we are of value over and above such things depends, in good part, upon us as individuals, our training, our experience, our insight, and our point of view. In my own observation, most of the clergy active in mental-health groups in a more than perfunctory way have been very much above the average of the profession as a whole.

It does not seem to me, however, that we clergy who are concerned both with mental health in general and with the mental-health movement in particular have had enough imagination or direction in our attempts at community leadership on mental-health matters. If I am to do something significant for mental health on a wider scale in the community, then it ought to be the type of thing that is plainly connected with my function as a spiritual leader—concerned for the total health and growth of every individual as a personal spirit including body and mind. I should not be made chairman of the finance drive, or secretary of the hospital-

inspection committee, although these things, too, may have religious aspects.

We had a nice illustration of a proper function during Mental Health Week in Illinois last spring, when, as chairman of the committee, I was invited to talk on religion and mental health before the Chicago Sunday Evening Club. This seemed to me inherently appropriate to my function as a clergyman. Societies may be able to help clergymen, not only to be community leaders on mental health in a general way, but to do this in such a way that their function as spiritual leaders is in the foreground. Such possibilities, mostly not yet explored, seem very large.

I have been much pleased at the decision by The National Association for Mental Health to form a committee on mental-health education. Properly interpreted, the clergyman can come into such a discussion and find its central concern very close to his own concern as a religious leader. It is as much to express my function as a minister as to evidence my concern for mental health that I have gratefully accepted membership on this committee.

The Preparation of Clergymen.—How many of our clergymen have had in their education that which will enable them to contribute positively to the mental health of the community? In replying to this, the first thing that must be said is that any priest, minister, or rabbi who is ministering to people according to the best of his religious tradition—even if he never heard of mental health—is making a contribution without which community mental health would be much poorer than it is. The Roman Catholic confessional was not designed as an aid to mental health, but it is so just the same—even if the priest thinks neurosis to be a new brand of breakfast cereal and delinquency to have something to do with taxes. It has often, and rightly, been stated that a man's religion is likely to be no better than he, or his whole character, is. But I have always felt we must add to that that a man's religion, if he has any, is very likely to be just enough better than he is to move him toward becoming what it is in him to become.

And yet the traditional resources are not enough. If we do not also incorporate the enormously important modern insights, we lose great opportunities in our ministry. If one

goes over the figures of improvement in the education of the clergy during the past quarter century, one's first reaction will be of pleased surprised at the extent to which basic mental-health matters are entering the curriculum. As many as ten thousand clergymen in these years have had some significant form of clinical pastoral training. Several additional thousands have had good courses on pastoral care and counseling and related subjects. In my own university, along with two or three others, we now offer even the Ph.D. degree to the brilliant student willing to plow through all aspects of these subjects both in their theoretical and in their practical manifestations. One cannot help being encouraged by such undeniable progress. Our monthly journal, *Pastoral Psychology,* has achieved something like twelve thousand subscribers in its four years of existence, making us, so far as we know, the second largest psychological journal in the world.

And yet more sober reflection forces us to qualify such optimism. One estimates that not much more than a third of the men going into the ministry of the several faiths each year have had any significant training along these lines. Even among some who do have such training, there is not always a guarantee, through the best educational practice, that it has genuinely sunk in. These is still a long distance to go.

Helping Clergymen to Help the Community.—Allusions have already been made to ways in which mental-health groups may aid clergymen to increase their contribution to community mental health. I have suggested especially the conscious linkage of the clergyman's community leadership with those activities plainly related to his religious function. I have also indicated the greatly increased chances of capturing the clergyman's imagination when mental health is uniformly discussed, not as something external to religious concern and aims, but as a partial means of fulfilling such aims. The first line in the recipe for rabbit stew is still: Catch the rabbit. Salt on the tail is too little and too late.

I have also been impressed with another way in which the clergy may be helped to make a larger contribution to community mental health—through inter-professional consultation, discussion, and even action. Everybody talks about

inter-professional coöperation, but outside of its necessary institutionalized forms (as in hospitals or agencies), nobody does much about it. And when some form of genuinely inter-professional discussion is envisioned, those in charge are likely to retreat before the first blast of protest that laymen should not be excluded. While I have nothing against laymen, there are some things that can be achieved by an inter-professional group that ought to be cultivated in their own right. Clergy as a group tend to be much interested in such things. Communities where they have been tried generally find results flowing from them far beyond what had been anticipated. Since mental health does concern various professions, perhaps mental-health groups can take this obligation more seriously in the future. There is no reason why it should conflict with broader activities in which laymen are of course properly included.

Finally, there can be more and deeper thinking about the nature of mental health itself—for the clarification of all concerned, to be sure, but also for getting mental health into perspective as one, but not the sole, aim of the human enterprise. Mental health requires activity, skill, organization, and many other things; but it also requires reflective thought that can break through protective walls and sacrosanct, but unexamined phrases, in the direction of the basic principles.

Mental health is not just the avoidance of mental illness, important as that is. It is not just practical psychiatry, important as psychiatry has been and is in relation to mental health. Mental health is more, and it is important to think this through and to be able to state it in the myriad ways necessary to catch the attention and concern of groups and individuals of all kinds.

But mental health is not everything. It is consistent with our high religious traditions, and can implement many of them. But it is not a competitor to them, nor a substitute for them.

If such things are deeply thought and often and variously said, they are important for the cause of mental health itself. And they can help more clergymen to be, more explicitly, widely, and effectively, agents of that mental health in the community that is a valid and necessary part of the Jewish and Christian traditions themselves.

PSYCHIATRY AND THE LAW *

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IN this series the various speakers are considering the relations of psychology to life and art, such as its relations to education and religion. Psychology deals with the behavior of the individual or groups of individuals, especially in his or their relation to the physical and social environment. Thus there are many applications of normal and abnormal psychology to problems of the social and legal relations of people.

For example, over thirty years ago, Professor Hugo Münsterberg, of Harvard, wrote a book entitled, *On the Witness Stand,* concerning the reliability—or rather the unreliability—in accuracy of the observation of witnesses. Psychological studies of the effects of punishment on the offender have been made, and there have even been some observations on the psychology of lawyers and judges! I have chosen to devote myself here to one particular type of psychology as it relates to the law—namely, medical psychology or psychiatry.

Psychiatry is a specialty of medicine, a specialty that deals largely with the deranged behavior of the individual. It has been defined as "the branch of medicine which deals with those persons who from a combination of circumstances, constitutional or acquired, are unable to adapt themselves satisfactorily to a particular situation in life because of certain signs and symptoms, certain maladjustments, which may or may not require treatment in the home, the school, the college, the factory, the clinic, nursing home or hospital."

I repeat that psychiatry is a branch of medicine, the specialty that deals with the whole person, and that it is properly practiced only by the medical man, with the aid

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of other medical specialties and of such ancillary disciplines as clinical psychology and social work. I emphasize this point because many of the public do not fully appreciate the fact that psychiatry is a part of the larger field of medicine. And lest there be further misunderstanding, let me remind you that psychoanalysis is a specialized psychiatric technique, properly practiced (outside of hospitals or clinics) only by the trained psychiatrist, and not a discipline independent of psychiatry. We should speak, not of psychiatry *and* psychoanalysis, but of psychoanalytic psychiatry and general psychiatry. A number of the fundamental theories enunciated by Freud are, indeed, common to all psychiatric thought.

Since psychiatry deals with human behavior, it is inevitable that it should have contact with the law at many points, for the law, like psychiatry, deals with the behavior of individuals. The rôle played by psychiatry in the administration of the law is advancing and becoming more important as the two disciplines come to recognize their mutualities as well as their differences.

The lawyer refers to "insanity." This is a legal term only, and one that is not used by the psychiatrist; the latter prefers to speak of mental disorder, mental illness, or of psychosis and neurosis. It should be borne in mind, too, that although the term, "insanity," is often loosely used as if it were a unitary concept, it is really no such thing. Actually, there are at least seven different meanings of the legal word "insanity," depending on the context in which it is used. Thus, the criteria of mental incapacity that make invalid a contract or deed are different from those required to invalidate a will. Fitness for commitment to a mental hospital is quite different from the mental disorder that warrants the appointment of a guardian or the nullification of a marriage, renders a defendant unfit to plead to a charge of crime, or justifies a verdict of "not guilty by reason of insanity." It is perhaps sufficient to say that although the lawyer sometimes criticizes the psychiatrist for his alleged vagueness, the legal term, "insanity," itself is far from being uniform in meaning.

Many volumes have been written on the topic with which I am to deal in a half hour and, for this reason, I must con-

dense materially what I shall present. For those interested in pursuing the matter further, I can recommend a recent book entitled, *Psychiatry and the Law,* by Dr. Manfred Guttmacher, of Baltimore, and Professor Henry Weihofen, of the University of New Mexico, and a book by Dr. Henry Davidson, of Washington, with the title, *Forensic Psychiatry.* I have myself dealt with certain aspects of this problem in my volume entitled, *The Psychiatrist and the Law,* published this year.

Among specific applications of psychiatry to the law, let us consider, first, the question of commitment to mental hospitals. In any year nearly a quarter of a million persons are admitted to mental hospitals of one type or another, many of them for short periods or for observation, and a certain proportion of them—particularly in California, Illinois, and Ohio—on a voluntary basis. Many mentally ill persons, however, fail to realize that they are sick and in need of hospital care, and for this reason legal provisions are necessary to compel them to enter a hospital and to remain there until their release is considered to be desirable. The laws of the various states regarding what is generally termed commitment show a great discrepancy. In some states, for example, admission is fairly easy, whereas in other jurisdictions—and I regret to say the District of Columbia is among these—there are many legal technicalities and formalities savoring of a trial, which make it difficult for the mentally ill person to be sent to the hospital, and which subject him to emotional strain at a particularly vulnerable time.

Dr. Isaac Ray, who wrote the first book in English on the medical jurisprudence of insanity, as he called it, over one hundred years ago, stated the proper aims of commitment laws thus:

> "In the first place, the law should put no hindrance in the way of the prompt use of those instrumentalities which are regarded as most effectual in promoting the comfort and restoration of the patient. Secondly, it should spare all unnecessary exposure of private troubles and all unnecessary conflict with popular prejudices. Thirdly, it should protect individuals from wrongful imprisonment. It would be objection enough to any legal provision that it failed to secure these objects in the completest possible manner."

The criterion, then, should be whether or not the patient, for his own protection and that of the community, needs to be deprived of his liberty and treated in a mental hospital. Obviously, this is a question that can be decided only upon medical evidence. Thus we find that in all commitments to mental hospitals some sort of psychiatric testimony from physicians is required in the course of the legal proceedings.

In another type of legal action, the question may be raised whether a person, by reason of mental disability, is no longer competent to handle his own affairs. The criteria of this disability are not necessarily—and indeed should not be—the same as those calling for enforced hospital care; in most jurisdictions the proceedings are independent and may be held in entirely different courts. That is, a person may not need hospital care although he is incompetent to handle his affairs, and vice versa. In any event, however, it is quite clear that the court, before appointing a guardian, a conservator, committee, custodian, or whatever he may be called in the various states, must have before it medical evidence based on examination of the patient.

In still another kind of proceeding, the question may arise whether the person was mentally competent at the time of his marriage to understand what he was about. Proceedings to dissolve the marriage tie on this basis are known as annulment. A new development in this connection is that, in an increasing number of states, the husband or wife of a person who has been so ill mentally as to have been confined in a mental hospital for a stated number of years and whose recovery is unlikely may be granted a divorce. Obviously, here again medical evidence is necessary. The criteria for contracting a valid marriage are not always uniform, and much depends on the attitude of the judge, and how much he bows to expediency in a given case. The question of divorce on the ground of "insanity" is somewhat more objective since, among other things, it calls for a certain number of years of confinement in a mental hospital.

Again, in certain types of negligence case, notably those involving automobile accidents, it may be alleged that the plaintiff incurred mental disability of some sort or other, whether in the nature of a neurosis or a more profound disturbance of mental functions. The number of so-called "trau-

matic neurosis'' cases seems to be increasing, and the juries appear to be much impressed with the seriousness of the damage. Indeed, many psychiatrists consider juries altogether too much impressed with the presumably poor outlook, whereas, as a matter of fact cases of this sort usually respond to treatment. The large and indeed inordinate verdicts of juries in cases of this sort reflect some of the peculiar notions that are cherished by the public with regard to mental disorder. Many laymen, for example, think mental disorder incurable, while others think that patients are sometimes ''railroaded,''—*i.e.*, sent to hospital and detained for ulterior motives, though not ill. These are but two of the ''popular delusions'' occasionally met with.

There is one type of legal action in which the person who is the subject of litigation is dead. I refer to contests over the validity of wills, in which it is alleged that the person who made the will was at the time not mentally fit to understand the nature and extent of his property or who were the ''natural objects of his bounty,'' to use the words of the law. Obviously here the psychiatrist is not in a position to examine the patient and almost always had no occasion to do so during the patient's lifetime. In this case the expert witness, as he is known, must answer a ''hypothetical question,'' which is supposed to embody facts that have been testified to by others in the proceeding. The criteria for testamentary incapacity, be it remembered, are quite different from those for commitment to a mental hospital, for example. Furthermore, the courts are extremely reluctant to disturb a testamentary disposition, since the person who made the will cannot be interrogated as to what he really meant.

It should be pointed out that some of the concepts of the law with relation to mental disorder show up particularly in will cases as being out of line with modern psychiatric concepts. The courts hold, for instance, that there is no such thing as a delusion founded on fact, and that if a condition ''results from a belief or inference, however irrational or unfounded, which is drawn from facts which are shown to exist,'' it cannot be referred to as an insane delusion. As a matter of fact most delusions have *some* foundation in fact, more or less slight, and involve misinterpretation and

elaboration rather than a spinning of the delusion out of thin air, so to speak.

These are some of the reasons why courts seldom upset a will on the ground of mental incapacity of the maker and why some wills have been sustained in the face of a testator's serious mental disorder. The law recognizes also that a person who is aged or seriously ill may be subject to "undue influence" in the form of blandishments or cajolery, and wills are sometimes upset on this ground rather than that of mental incapacity.

Somewhat similar criteria, although not quite so rigid, apply to deeds and contracts and their validity. Here ordinarily the maker of the deed or contract is at least alive and can be examined, so that the testimony is based somewhat more on fact and actual observation than on hypothesis.

I have left until the last in this enumeration the consideration of the criminal law. I have done this largely because the public has an entirely wrong idea of the relative importance, at least numerically, of criminal cases in which psychiatric testimony is introduced. Civil cases outweigh the criminal cases tremendously; in fact, the criminal cases in which the defense of insanity is pleaded are practically infinitesimal in number. Yet by reason of the great notoriety that they receive, and the public feeling engendered by them, they bulk large in the imagination of the public.

There are several stages of the proceedings at which the question of mental condition may arise. It may be found, for example, that the defendant is mentally unfit to plead—that is, that he cannot understand the nature of the proceedings and cannot advise properly with his counsel.

Next, if he is found mentally fit, the question may arise whether at the moment of the act alleged, he knew what he was about, as we say. The general test is whether he "knew the nature and quality of the act and knew that what he was doing was wrong." This is generally referred to as the "right and wrong test." This test comes down to us from over a hundred years ago, having been propounded in answer to some questions addressed to the judges of England in the case of one Daniel McNaghten. The British Royal Commission on Capital Punishment, in its recent report, has stated that this rule "is so defective that the law on the subject

ought to be changed," and they have recommended adding to the knowledge test what may be referred to as a volitional test—that is, the question whether the defendant at the time of the act was able to prevent himself from committing the act. This addition is the substance of what is known in some of the American states (about nineteen) that have adopted it as the "irresistible impulse" test. Certainly knowledge of right and wrong is not sufficient in itself to constitute a valid test, and it is to be hoped that some day this test will be very substantially modified.

Finally, it may be found after a man is convicted that he has become mentally ill, in which case arrangements may be made to transfer him from his place of confinement to a mental hospital.

More recently, the law has come to recognize certain border-line conditions. The original theory was that a person was either completely sane or completely insane, but it is now recognized that there are persons who are neither one nor the other. I refer particularly to the so-called "sexual psychopath" legislation, now in force in at least fifteen states and the District of Columbia. In this type of enactment, we find provision for the indeterminate commitment of certain sexual offenders who are recognized as mentally abnormal, but who are not, in the eyes of the law, insane. The "sexual psychopath" laws, though based on psychiatric concepts of dubious validity, seem to point the way toward a more realistic dealing with some problems of disposition of the offender.

I cannot close my remarks without some mention of the methods of introducing before the courts testimony relative to the mental state of persons who are the subject of litigation. There has been much criticism of psychiatric-expert testimony. There are, of course, many kinds of expert, and if one thinks that psychiatrists disagree on the stand, one has only to read the testimony of some of the conflicting real-estate experts to realize that psychiatrists are by comparison practically unanimous! The principal objection to expert testimony in general is that the expert is usually presented by one side or the other, so that immediately he comes under the suspicion of bias and partiality. This fact is bound to affect his credibility in the eyes of the jury or the judge. Then, too, courts have not always exercised carefully their

right to determine whether the expert really is qualified—that is, whether he really is possessed of special knowledge acquired either by training or by experience. Some of the pseudo-experts who have testified have given testimony that might be referred to as almost fantastic, and have conferred on the whole group of experts no benefit whatever by their example. This is especially true in criminal cases, on account of the notoriety of the case itself.

One of the greatest steps forward in the presentation of this kind of testimony would be the court appointment of the expert, so that he would be neutral, not an apparent partisan. In any event, experts should attempt to treat one another as professional men and consult together in legal cases just as they do in the sick room. The hypothetical question is another factor in magnifying such apparent differences as there may be in the testimony of the experts.

It cannot be denied that there is much room for improvement, but there are ways of bringing this about. In criminal cases, for example, Massachusetts has, since 1921, provided for an automatic examination by neutral experts of all persons accused of capital crimes and of certain other persons indicted for serious offenses. This law is known as the Briggs Law, after its author, Dr. L. Vernon Briggs, of Boston. Under its provisions, those defendants who come within its scope are automatically referred to the department of mental health, and are examined by two physicians appointed by the department. The examiners are thus both neutral and competent, meeting the two most important criteria of reliable witnesses. Likewise, the automatic reference means that there is no likelihood of putting on trial a mentally incompetent defendant, while the probability of a specious plea of insanity is reduced almost to zero. This procedure has eliminated the "battle of experts" that have brought such discredit upon expert testimony.

In passing, we may note that less than 20 per cent of the defendants have been reported as suggestively or definitely abnormal mentally; indeed only 1.2 per cent were reported as psychotic, while another 6 per cent were recommended for observation, in a mental hospital; the rest were mostly of more or less impaired intellectual development.

This valuable law has been copied so far only in Michigan

and Kentucky. The Uniform Expert Testimony Act, proposed by the Commissioners on Uniform State Laws fifteen years ago, has been adopted so far by only South Dakota and Vermont. Briefly, this act provides for court-appointed experts in addition to those selected by the respective parties; they are encouraged to make joint examinations and reports. A hypothetical question is not required, although of course the reports are subject to cross-examination. Finally, the number of experts and their fees are controlled by the court. It seems strange, with all of the criticism that has been heard in various circles concerning expert testimony, that not one of the larger states has taken this step toward improving the situation.

In the past there has been some distrust between doctors and lawyers, but this is gradually being broken down by the increasing attention now given in law schools and medical schools, such as those of the George Washington University, to training the students in the views and attitudes of their colleagues in the opposite profession. Mutual understanding contributes more than any other factor to mutual respect. To-day we find an increasing readiness of the law to recognize the value of the contributions of psychiatry and their practical application to the problems of human behavior.

A DYNAMIC APPROACH TO IN-SERVICE TRAINING IN A PSYCHIATRIC SETTING

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IN the average state hospital, administration, treatment, and training are considered to be three separate functions, with different prestige values. Administration is considered mostly "scut work"—something necessary, but uninteresting, even, in fact, beneath the dignity of the well-trained therapist. Treatment and training are considered more worthy of the physician's exercise of his skills. We disagree with this, in that we believe that, essentially, training is merely one aspect of a process of which administration and treatment are other, inseparable parts. None of these part processes can operate without the others, and each one presents a comparable challenge to the skill of the dynamically oriented psychiatrist.

We wish to present the point of view that the coördination of the administrative and treatment processes can be used in the training of the young psychiatrist through a dynamic approach to his supervision on the job.

The search for training opportunities in psychiatry has been one of the most significant aspects in the development of the old asylums into modern psychiatric hospitals. This search for training opportunities was greatly intensified when large numbers of doctors were released from the services during the last war. The most desirable jobs were those in hospitals in which both analytic training and credit toward board certification were available. Hospitals that could not offer more or less organized learning opportunities either within or nearby had difficulty in recruiting staffs. Accordingly, the development of training opportunities was greatly emphasized.

Many hospital administrators, in trying to set up programs that would attract doctors, found themselves in a dilemma. The most sought-after type of training was that of the psychoanalytic school of psychiatry. This may have been due, among other factors, to its being the most widely organized school of thought. But many administrators had, with good reason, come to look upon analytic training as not consistent with the best interests of the hospital. Analytic training, as experienced by the trainee, emphasized a close interpersonal relationship generally possible only between a therapist and a single patient. The administrator, on the other hand, was faced with the problem of treating large aggregates of patients. What good to him was a doctor whose case load was—if he utilized only those methods in which he was trained—limited to a few patients?

On his part, the trainee, too, found the situation in many state hospitals not to his liking. Aside from the resentment administrators seemed to feel for his theories, he, too, was perplexed and frustrated when he recognized how inadequate to the task at hand his theories were. While many struggled to find answers to the problem by means of various adaptations of the technics available, many more succumbed to the frustration of the situation, and came to look upon the state hospital as a place in which the constructive application of dynamic principles was impossible. The trainee found the duties required of him falling into an entirely separate category from the work he was training for and liked to do. The former became a series of onerous chores, whose very necessity only made their discharge the more irritating.

But still, the work was there to be done, and administrators had to devise ways of seeing that the doctors did it. The solutions of this problem varied all the way from attempts, on the one hand, at rigid control of the doctor's activities, with detailed checks on how he spent his time, to, on the other hand, situations in which the doctor was given the greatest freedom to select the tasks he felt like doing, with little or no supervision and coördination of over-all efforts. Often, such a solution as was achieved represented only an uneasy compromise in which each side resented the attitudes of the other. In some hospitals, in order to resolve these problems, a director of psychiatric education and training was appointed.

This often served only to emphasize the schism between training and routine-job performance.

In spite of these handicaps, a lot of good work was done, and much was learned about the application of the dynamics of interpersonal relationships to institutional treatment, even though the effective utilization of the doctors' time and skill was greatly hampered. Where training programs were created mostly in order to attract doctors, instead of on the basis of the administrator's conviction that training was necessary, there often arose an emphasis on the needs of the doctor rather than on the needs of the patient.

Obviously, in this situation, the mass of patients suffered. But aside from this, the doctor himself missed an opportunity to inquire into another important area of interpersonal relations. This area was concerned with how the doctor's personality became involved in any therapy situation. Therapy, essentially, is built on a disciplined approach. The less disciplined the setting in which the doctor worked, the less opportunity he had for noticing his own problems in meeting discipline. Thus, it seemed to us that greater integration of training with administration would lead to an increase in the therapeutic and training potentialities of hospital administration.

In developing this idea with respect to the treatment of large aggregates of patients, we looked more carefully at what there is at present in a state hospital that contributes to the recovery of patients from their illness. The answer seemed to be the hospital life itself. Even without modern methods of therapy, patients do seem to fare better in a state hospital than at home. Also, as psychiatrists have often noticed, patients transferred from a private hospital, in which they had failed to improve under a supposedly superior level of care and treatment, often improve rapidly in a state hospital.

It seemed to us, in examining this question, that the predominant characteristic of state-hospital life is its rather rigid routine. There are regular hours for sleep and meals. Those patients who are capable of performing routine tasks are expected to do so. Reality demands this, and patients generally accept it. They find stability where many of us see only a dulling monotony. They become upset when this routine is interrupted. There are other factors, presumably,

but we felt that the aspect of hospital life that is so often condemned is one of the very elements that contributes toward the patient's improvement. Having decisions made for him, being lost in the anonymity of a ward of patients, gives him a form of much needed security that frees him to use his own powers of restitution. The expectation that the patient will be able to control his behavior sufficiently to take part in routines and to perform simple tasks appeals to the "well" side of the patient and encourages him to see himself as capable of living up to at least a simple environment in a worth-while way.

The segregation of patients into wards based on their ability to behave in a conforming manner represents at the same time a challenge and a consolation to the patient. The more disturbed the ward, the more limited the freedom to join in common activities. But within the limitations comes an increase in permissiveness, so that the patient in a seclusion room finds himself free to indulge in infantile mechanisms, whereas the open-ward patient must constantly be aware of the effects of his actions on others. Thus, the patient is at all times confronted with the choice between moving about in a responsible manner and being confined in a place in which he may act irresponsibly.

The administration of the hospital is, on its own part, also routinized. The work of the hospital proceeds in general in an orderly way. Rounds are made, progress notes are written, and other activities are carried on because they represent a system that has been worked out over the years as the most practical way to deal with the job. If the activities often are performed more because they are accustomed routine than because they make sense, their effectiveness is not thereby seriously hampered, and the hospital is thus able to continue to operate in spite of all sorts of disorganizing factors.

The establishment of wards with degrees of permissiveness allows for the dynamic use of the patient's willingness, or lack of willingness, to inhibit the free expression of his infantile drives, in return for greater participation in the world of reality and responsibility. The physician is able to place the responsibility for this decision on the patient by carefully adhering to the limitations of behavior imposed by the structure of the ward. This helps the patient to discover for him-

self the way in which his behavior promotes or interferes with the achievement of his goals. It is only as the patient is able to yield to the limitations of the routines that he is able to gain strength and security to deal with the realities of living.

Rigidity alone, of course, is not the means by which patients are helped. The permissiveness—the feeling that, here, abnormal behavior is the expected mode—is combined with the rigidity in a way that represents the best possible compromise in meeting the needs of the greatest number of patients with the minimum number of employees. With the improvement in standards of patient care, more cognizance is being taken of the needs of individual patients. But the time when treatment in state hospitals will be dictated solely by these individual needs is too remote to contemplate. So we are left with the problem of how to make that which is valuable in any state-hospital routine more effectively utilizable.

The young doctor in a state hospital is likely to see only the negative side of the routines and limitations. As he becomes more experienced, he begins to sense the value of this settled type of environment. Often, if this realization occurs gradually and without elucidation of the dynamic values of the stability, the process appears to outside observers as a futile resignation to the massive inertia of a state hospital. But most experienced hospital administrators know, even without necessarily exact knowledge of the mechanics, the positive values of state-hospital routines. The answer to the problem, then, lies in the direction of being able to help the trainee discover early in his training the exciting dynamic use of the realities of hospitalization.

The trainee, facing the enormities of the task of caring for so many people at once, will usually be burdened by a deadening sense of frustration. He will be subject to strong pressures to allow deviations from the routines in the form of special privileges, and so on. These pressures arise from the patient's ability to manipulate his environment by playing upon the reaction of the physician's personality to the patient's apparent unhappiness. The need to resist these pressures is not always easy to explain to the trainee, and even if explanations are intellectually accepted, the physician cannot use them to full advantage in enabling himself to deal objectively with the pressures. Just as the value of the discipline

necessary in successful psychotherapy is best demonstrated through subjectively experiencing this process, so the value of the discipline of hospital routines is best taught by allowing the trainee to experience its effects.

The trainee can undergo this experience through the proper use of administrative supervision. Supervision of one sort or another, is, of course, essential to a well-run hospital. But the kind of supervision needed to accomplish the task we are discussing must be one that brings out the attitudes that the trainee brings to his job, and the way in which he uses himself in doing the job. Such supervision must be set up according to a rather definite structure. It is a structure that has been, for the most part, developed by social workers as the most effective technic for training, as described by Dr. Virginia Robinson in her book, *The Dynamics of Supervision Under Functional Controls.*

The structure of this type of supervision is a firm one, and it provides a background against which the trainee can measure his attitudes. It corresponds to the firm background of structure which the hospital provides for the security of the patients. This kind of supervision begins with the employee's acceptance of his job. At the very beginning, the supervisor attempts to reach a clear understanding with the trainee as to what his job entails. What does he bring to a job? What does he expect from it? The feelings that the new employee brings to a job must be talked about, the negative as well as the positive aspects being observed. It must be made clear that acceptance of the job, with its limitations and responsibilities, is the employee's free choice. The supervisor can always use this acceptance as a point of departure in discussing any future changes, as well as the employee's regular performance.

The supervision itself must be considered as one of the requirements of the job. The regularity of interviews, the subject content of the interviews—this must all be accepted as just as real a part of the job as the other duties. The interviews must be scheduled regularly and the schedule adhered to, with the same rigidity as in the case of psychotherapeutic interviews, and for similar reasons. If interviews are not scheduled, their frequency and duration are likely to be deter-

mined by the trainee's feelings toward the supervisor, rather than by the requirements of the job.

Just as, in the therapeutic process, the uncritical acceptance of the patient's expression of his needs enables him to face these needs, so in supervision, the trainee is enabled to face the way in which he uses himself in dealing with patients, whether in intensive psychotherapeutic processes dealing with individuals or during relatively fleeting contacts with large numbers.

The trainee is enabled to discover at first hand the difficulties inherent in the taking of help in the learning process. As a result, he can more readily understand the resistances that his patients show to taking help.

Having experienced the discipline of limitations, the doctors are able to understand the way in which patients can use limitations. The doctor is then able to see the routine of the hospital, not as monotonous and frustrating, but as challenging and dynamic, as is life itself. The patient makes requests of the doctor for privileges, not on the basis of what he feels he has earned, but on a more infantile level, such as that, being his desires, they should be granted. Finding himself thwarted by the reality limitations of the hospital, he reacts in his own characteristic way. He tests himself against the limitations. If the limitations are allowed to yield to his maneuverings, his regressive tendencies are emphasized. He learns nothing. But if the limitations hold firm, the patient may then be able to feel secure enough to attempt a more realistic appraisal of the limitations. By this testing of himself, he could, with proper support, learn how he uses himself in real-life situations.

Of course, not all patients are able to use the ward situation as a means of regaining mental health. More, though, could profit from this type of firmness with acceptance, than could benefit from a more vacillating type of administration.

For the full effectivenss of this type of supervision, the administration must be authoritative, rather than authoritarian. To quote Erich Fromm, in *Man for Himself*, "rational authority is based upon the equality of both authority and subject, which differ only with respect to the degree of knowledge or skill in a particular field." A type of administration in which the "boss" makes all the decisions is bound to be

limited in scope and effectiveness. The workers in such a setting, if they are not complete automatons, will develop a degree of resentment that will make their efficient functioning impossible. An administration that recognizes that policy can best be executed by those who share in the making of policy will be more efficient both in the administrative and in the operating branches.

A clear understanding of the policy under which he works, or which he administers, is vital to the trainee's grasp of the work he is doing. Accordingly, the hospital structure must make provision for the participation of trainees in the development of administrative policies. This is done through the use of administrative meetings, held at regular intervals, in which all administrative decisions are discussed. Clearly, some decisions must be made at high levels and passed down. But in most instances, the decisions as to routines to be followed, and so on, can be formulated in these administrative meetings. This allows for an orderly process of change in the hospital structure. These meetings take on a resemblance to group therapy, in that many of the tensions that ordinarily plague a hospital can be brought to light and dealt with, if the group leader is cognizant of group dynamics. The feeling that he is taking part in the administration of the hospital tends to decrease the gap between the trainee and his supervisor. Through increasing his security, this enables him to be more accepting of the supervisor's evaluation of his work and his attitudes.

The formal aspects of training, such as lectures and seminars, are frequently considered the center of the training effort. But viewed in the light of the above ideas, these activities become purely adjunctive. Lectures and seminars are geared to the main training effort, which is the supervision of the trainee's functioning in the job. What is learned in the lectures is important only in the light of how it enables the trainee to function better.

In this connection, we would like to mention the traditional idea that intensive psychotherapy, particularly psychoanalysis, holds a special place in the treatment and training programs of the state hospital. Not only is it expensive, but it is endowed with a certain glamour. This place, we believe, has been come by falsely, out of ignorance of the real possibilities

of dynamic treatment of aggregates of patients. Sullivan pointed out that we do not act on one level of maturity with our patients and on another with our daily associates. Similarly, we do not make one use of our personalities with those patients whom we treat intensively, and another with those whom we contact more casually. The administrative supervisor, in assessing the attitudes and functioning of the trainee, is just as interested in the attitude that he demonstrates in intensive psychotherapy as in the one he demonstrates in prescribing shock therapy.

Psychotherapy is a tool in the armamentarium of the well-rounded hospital. Selection of patients for this treatment should be made by the same process by which patients are selected for shock treatment. Although special attention may be given to the teaching of these technics, their use, in relation to the total therapeutic program of the hospital, is a continuing concern of the administrator in his interviews with the trainee.

We see, then, that administration, treatment, and training are not separate functions of a state hospital, but are inextricably bound together as parts of the same process, and must be centered in the job to be done. Sound treatment is based principally on a knowledge on the administrator's part of the way in which the patient's personality reacts to the realities of life. It also presupposes an understanding of the patient's needs to assault these realities and exercising of judgment as to when it is safe to yield and when it is wise to stand firm. Training consists of imparting this same knowledge to the young doctor by helping him see, through his own experience in supervision, the dynamics of the therapeutic job. The professional maturity that the psychiatric trainee can achieve through this disciplined experience will be of equal importance in a state hospital and in private practice.

A PEDIATRICIAN'S PLAN FOR MENTAL HYGIENE

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THE problem of mental hygiene is becoming increasingly important to all of us who work in the field of medicine and public health. As we gain control of more and more of the infectious diseases, through newer medicines, immunizations, and widespread public-health programs, we are becoming increasingly aware of the mental-health problem. It is obvious that we must develop good programs for mental hygiene. This cannot be done by psychiatrists alone. They are overloaded with the care of people already significantly mentally disturbed. Therefore, mental hygiene is the responsibility of all in medicine and allied disciplines, and each will approach the problem in the light of his specific knowledge.

The pediatrician has a twofold interest in this problem. First of all, his major concerns are in preventive medicine. Secondly, he is called upon to advise parents regarding the care of their children from infancy through childhood. This service often starts during the very first days of the infant's life, and there could be no better time to begin a mental-hygiene program. Pediatricians are constantly increasing their knowledge of the emotional and mental growth of children, and the psychological problems of early childhood, and are thereby better fitting themselves for this task.

The problem is: What mental-hygiene plan should the pediatrician follow and how? One can give good advice on the management of the various day-to-day problems, to minimize stress and conflicts. However, in so doing, we run the risk of giving too much definite and detailed advice and making the parents dependent on us. It is sometimes easier to do things for people, but the results are often temporary and the parents themselves weakened. On the other hand, if they can be stimulated to assume more responsibility and can be guided to

make wise decisions themselves, the results may be more lasting and the parents strengthened in the process. We would have effective mental hygiene if parents were able to make wise decisions regarding the management of their children from infancy to adulthood. The parents' ability to do this is dependent upon their gaining some knowledge and insight into the mechanism of human behavior.

A Basic Principle of Behavior.—I should like to consider the following, necessarily oversimplified, statement as a working formula for the understanding of human behavior: *Our needs (or motives) cause us to act, and our resources determine the possible ways in which we act. The resulting action itself is our behavior.* Under the term "needs," I would include only the basic drives, motives, or urges. By "resources," I mean the physical and mental abilities of an individual as well as his learned skills at a given stage of his development. For example, a newborn baby may be driven to act by hunger, and with his limited resources, the resulting behavior is a vigorous cry. Whereas a two-year-old child who is hungry may seek out his mother and express his hunger in words. The need is the same, but the resources have changed through development and the behavior is different. This may sound too simple, yet it is difficult to grasp these concepts unless one has some understanding of the development of children and some skill in observing them.

In stating this concept of behavior, I wish to make no implication as to the relative importance of each of these factors. Nor do I wish to indicate that a special doctrine regarding the satisfaction of all needs or the understanding of developmental phases is the "right" way. I believe that the "right" way is an individual problem for each parent and child and that it must take into account their home and community situation. However, if parents are to act wisely and to individualize their family life successfully, they should have some knowledge and insight into the mechanisms of behavior as indicated. Since many parents have little or no experience with children prior to the birth of their first baby, it is important to aid them in gaining as much knowledge as possible from their experience as parents. They should also be helped to have as much confidence as possible that they can make and are making wise decisions.

The Pediatrician as Educator.—Unfortunately, books alone are not enough to give parents this knowledge and skill. Part of the reason is that a single book is often necessarily limited to one aspect of behavior. That is, the book discusses primarily motives, developmental stages, or just the resultant behavior and how to manage it. Even when parents read books that cover all of these phases, it is hard for them, because of their limited experience, to correlate the three. They are often confused into considering the books conflicting in content. The fact that there are in addition books with conflicting ideas adds to the confusion.

The pediatrician really has a wonderful educational opportunity set up for him. The new parents are strongly motivated to learn and, as John Dewey has pointed out, we learn best through the stimulation of our powers by the demands of the situation in which we find ourselves. In addition, in this case, the subject matter, the infant, is in its simplest state of development. At no time in life are the motives to act more directly apparent and more limited by resources in types of behavior response. There could be no better time to begin to understand the fundamental concepts of behavior, and then to learn the increasing complexities of this problem in graded stages as the baby grows.

The first major opportunity for parents to acquire this knowledge and develop this skill is presented by the problem of infant feeding. Self-demand feeding is particularly useful as an educational tool for the parent. In this situation the problem is not terribly complex, yet it is not simple. Not all crying in the first few months of life is due to hunger. The parent is required to think about the needs of the baby and why he may be crying at a given time. This is the beginning of the development of skill in observing children relative to their needs and their ability to satisfy these needs. I appreciate, of course, that self-demand feeding is not applicable in all family situations. However, other feeding programs present similar educational opportunities in varying degrees.

An attitude on the part of the doctor that permits the parents to request helpful advice at any time is essential to relieve some of their anxiety regarding the proper management of infant feeding. On the other hand, the doctor should be careful to lead the mother or father into proper conclusions

by artful questioning rather than by categorical answers. A new mother will gain confidence in herself and learn more rapidly if, when she makes a decision of her own, the doctor accepts this decision or modifies it only slightly, even though it may vary from the doctor's usual routine—unless, of course, her decision would be definitely detrimental to the baby.

In this manner, with some help from the doctor, the mother truly learns directly from her baby about one of the fundamental components of human behavior—namely, the basic needs her baby is trying to satisfy. She learns to think about these needs and watch for them at a time when the behavior of the baby is limited by his lack of development.

Very soon, in addition to this, the doctor has the opportunity to point out to the mother the manner in which the developmental changes in the baby are modifying this behavior. The baby who at one month of age is eating six or seven times a day, regardless of how much he is fed or takes at a feeding, will be eating only four or five times daily when he is three months of age, even though sometimes a smaller total amount than at one month. This same baby at one month of age cries violently the minute he is awake and stops only after he is fed, or even then cries intermittently if he stays awake. However, when he is three months of age, he will often lie awake a short time before he fusses for food and will have long periods of contented wakefulness.

These changes in the baby are related to his developmental growth. He is becoming increasingly diversified in his resources. The regularity with which these changes take place in normal infants permits the doctor to anticipate them in discussions with the mother. Thus, she learns to look ahead and to recognize developmental changes as they appear. Again, from her own baby, with the help of her doctor, she is increasing her knowledge and skill in understanding human behavior. This time she is learning about another fundamental aspect of behavior—that is, the influence of the resources of an individual on the manner in which he responds to a need or motive.

Although I have discussed only infant feeding, I do not mean to imply that this is the only important behavior to be understood in the early life of the infant. It is, however, an immediate and tangible subject for discussion with the parent, around

which one can begin to develop the mental-hygiene education as I have presented it. Starting in this manner, it is sometimes easier to proceed to the less tangible and more difficult concepts of other pleasurable relationships between the baby and the mother. Thus, the newborn baby who is accused of being "spoiled" if he is quiet and relaxed when held by his mother, but cries when she puts him down, is more easily defended.

The Parents' Development.—Throughout the first year of the baby's life, the opportunities are legion for the mother to observe in her own child, and thus learn more readily, the relationships between the child's needs, his resources, and his behavior. The general practitioner and pediatrician who see the mother, her baby, and sometimes the father, every month during this first year of the baby's life can guide the mother readily through the progressive stages of the increasingly complex development and behavior of the child. She is much more likely to learn and understand in this way than she would if she relied on her reading knowledge alone.

Admittedly, after only one year of experience and that limited to one child, a mother's knowledge regarding all human behavior is limited. Her real strength is in the understanding she has gained of the fundamental components of behavior during their less complex stages and also the skill she has acquired in observing her child's basic needs, as well as a method for analyzing observed behavior. These alone should give her an effective approach toward any problem she may have to face with her child, regardless of a lack of previous knowledge of the problem at hand. These are her tools for mental hygiene, tools that she keeps and improves on long after she has stopped taking her baby periodically to the doctor.

Indeed the doctor is fortunate if he continues to follow a baby through its second year of life. These visits are usually not as frequent or as regular as during the first year, yet it is during this year that the mother's understanding and skill are truly put to the test.

Generally, during the greater part of the first year, the baby's behavior is accepted and not judged "good" or "bad" in relation to his society, because he is still so young. During the second year of life, however, partly because of his in-

creased motility, the child truly begins to feel the impact of society. The parents begin to feel that from now on he has to learn how to live according to our customs. Weaning, bowel and bladder training, obeying the parents, and so on appear as problems for the child and his parents to struggle with during this year.

A parent who during the child's first year has learned to look for the child's real needs behind his behavior, and understand the way in which the child's resources influence his behavior, will find this second year meaningful and not alarming or difficult. Such a parent is not likely to judge a specific behavior as "good" or "bad" or immediately consider it an index of her success or failure as a parent. This parent also understands that the child's resources limit his understanding of "bad" and "good." He or she realizes the speed with which the resources of children develop and expand in this early period. A child whose behavior is judged as "bad" one month may change to behavior judged "good" the next, as a result of developmental growth alone. This parent also understands the variability of development in her child and is willing to wait for these changes to appear and to accept the limitations of the present.

In this way the serious child-parent conflicts of the preschool years that are found to be so significant in later childhood and in adult neuroses may be avoided. I realize, however, that the results fall short of the ideal picture presented here as a possibility. I am also aware of a certain group of parents who would not be able to participate effectively in such a program because their own emotional conflicts are too severe. These I would refer to the more competent hands of the psychiatrists.

There is also a group of parents who seem to have, from the beginning, all of this understanding of human behavior and skill in observing it. They have an "intuitive" ability to understand any situation and to make the right decisions. From these parents a pediatrician can learn. However, I believe that between these two extremes, there is a large middle group who are emotionally stable and who can profit by an educational mental-hygiene program administered by the practicing pediatrician in the general manner I have outlined.

A STUDY OF THE EFFECTIVENESS OF A WORKSHOP METHOD FOR MENTAL-HEALTH EDUCATION *

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AS part of a series of studies in evaluating methods and effectiveness of mental-health education, the research and education sections of the Michigan Department of Mental Health designed a project to evaluate the workshop method for teaching lay people accepted child-rearing concepts. The over-all project consisted of two main phases: (1) measurement of increment of information and its generalization in regard to the topics under discussion; and (2) observation of the self-oriented needs expressed by participants and the effect of these needs on achievement and assimilation. This paper is concerned with the first phase of the study.

A previous study had revealed the goals of mental-health education as selected by a group of experts,[1] and the content of this workshop was based upon one of the major goals these experts had selected—namely, the promotion and maintenance of good mental health in children. More specifically, the content of the workshop was designed to teach parents, teachers, and public-health nurses the general phases of psychosexual development, to develop an understanding of the meaning and use of the concept of permissiveness, and to promote comprehension of the need to channelize aggression into constructive behavior.

The workshop was held in the Upper Peninsula of Michigan in a resort hotel. This was a somewhat unusual atmosphere

* This report is the second of a projected series involving evaluation of procedures in mental-health education, now in progress in the Michigan Department of Mental Health.

The author wishes to express her indebtedness to Mary Weaver, who directed the workshop, and to F. Wollaeger, H. Lamb, E. Fitz-Hugh, J. Curvey, and B. Wilcox, who acted as resource people for the small discussion groups.

[1] See "The Goals of Mental-Health Education Commonly Selected by a Group of Experts," by Gwen Andrew and Esther L. Middlewood. MENTAL HYGIENE, Vol. 37, pp. 596–605, October, 1953.

for Michigan workshops, which commonly have been held in camp settings. The major difference here was that many of those who attended did not stay at the hotel, but commuted from their homes, and consequently some missed one or more of the group sessions. In the data reported, results are included only for those who attended all of the workshop meetings. This unusual setting for the workshop may also have resulted in a change in the group atmosphere ordinarily found in camp settings, where the group members spend most of their time together.

Plan of the Experiment.—The research was designed to test the relative effectiveness of several methods of presenting material in a workshop setting. Each method was used to present rather specific material in order to insure that measurements of change could be related to certain teaching techniques. The four methods were: (1) a panel discussion made up of lay people, presenting the pamphlet by Edith G. Neisser, *How to Live with Children*;[1] (2) a lecture on psychosexual development;[2] (3) the film, *The Face of Youth;*[3] and (4) two recordings from the *Inquiring Parent Series*—"Dealing with Destructiveness" and "Moral Training of Children."[4]

On arrival at the workshop, the audience was divided into small discussion groups of from seven to ten people, who were selected to include nurses, parents, and teachers. These groups, maintaining a consistent membership, met after each general session of the workshop. Because of the widespread use of "resource people" in groups of this type, an attempt was made to evaluate varied approaches frequently considered effective for resource people to use.[5] Eight groups were formed, and each was assigned a resource person who

[1] Chicago: Science Research Associates, 1950.

[2] Given by Esther L. Middlewood, of the Michigan Department of Mental Health.

[3] Distributed by the Bureau of Visual Instruction of the University of Wisconsin, Madison, Wisconsin.

[4] Distributed by The National Association for Mental Health, New York 19, N. Y.

[5] For this workshop, a *resource person* is defined as a person of special competence in the subject matter to be discussed. This person is not designated as the leader or chairman of the group, although in effect he usually functions as such. In this workshop, each discussion group selected a chairman from its membership, but for ease of discussion in this paper, *resource person* and *leader* are used interchangeably.

was instructed to present material in a given way on the basis of a resource person's manual, which was prepared to cover topics presented in the general sessions. The manual was written for several purposes, but primarily to insure the same frame of reference and orientation from each resource person.

The eight discussion groups were divided into four sets of two groups each, and the resource person for each group was asked to carry out his responsibilities according to one of four methods. This permitted each method to be represented by two resource persons. It was assumed that differences in the achievement of the four types of group could be attributed to the methods of these resource persons, and that this assumption could be tested by comparing the results of the groups in which the same method was used. The four methods were:

1. *The group-oriented approach,* in which the resource person accepted the feelings of the group members and offered interpretations, clarifications, and summaries of the group activity. The resource person attempted to steer the discussion to cover the topics in his manual, but this was always considered secondary to the attempt to meet group needs and no effort was spent to force the group to discuss any particular topic.

2. *The authority approach,* in which the resource person, acting as an expert, presented the material in his manual and attempted to direct the group discussion to cover the material discussed in the general sessions. This approach was not interpreted to mean that the resource person should act in an authoritarian or overly aggressive manner, but that his function should be that of an expert who possessed information that would be helpful to the group.

3. *The question-answer approach,* in which the resource person was established at the first small-group session as a professionally trained person who could be called upon to answer questions. This person then made no attempt to direct the discussion, but simply answered any questions asked by members of the group.

4. *The leaderless approach,* in which no resource person was assigned to a group and no guidance was offered to the group in its discussions.

Methods of Measurement.—The content of each presentation method (film, records, lecture, panel discussion) was carefully studied, and a set of questions was developed covering the subject matter included by each technique. An additional set of questions was prepared which attempted to test whether or not workshop participants were able to generalize the information they had acquired. These generalization questions consisted of hypothetical situations with a set of alternative ways in which the situation might be handled. The participant was asked to choose the most adequate of these alternatives.

The test made up of these two types of question consisted of 30 items. As a pilot study to try out the measuring device, these 30 items were pre-tested on a group of 20 people, and on the basis of the results a revision was prepared. After further trial, the final form was presented to a group of people of differing backgrounds who were in college, but who had not had courses in the subject matter covered by the workshop. The same test was administered a second time to these college people after a lapse of two days, which was equivalent to the period to be covered by the workshop. This group, then, was the control group for the study.

At the workshop, the participants were given an explanation of the need to evaluate techniques and were asked to coöperate by answering the questions. Considerable effort was made to minimize the threat of testing, to make it clear that the results were anonymous, and to indicate that the questions were essentially testing the work of the education division, rather than the individuals involved.

The test was given a second time at the close of the workshop, and again an explanation was given covering the use of the results. At the second presentation, the group became disturbed, vocalizing objections to taking a test on which they would not know their own results. An effort was made to accept the feelings expressed and to reassure the entire group. Also, after the test papers had been collected, answer keys were given to the group for inspection. It was possible to make contact with certain individuals separately when observers, who were studying the members of the groups for another phase of the experiment, reported that these people needed further reassurance.

Results.—Following the pattern suggested by Hovland and his associates,[1] a comparison of the groups' results on tests 1 and 2 was made in terms of an *effectiveness index* for each item of the test. This procedure avoided the problem of the varying initial levels of information which have such an important effect on the amount of improvement possible. The effectiveness index indicates the percentage of change that occurred as a function of the total possible change.

The control and experimental groups were first compared to determine whether or not there was a significant change in the workshop attenders' test results that was unaccompanied by the same change for the controls. It was found that there was no significant difference between the mean scores of the experimental and the control groups on the initial testing (experimental group mean was 18.5, N—39; control group mean was 20.6, N — 36; $t = .94$). This indicates that the groups were comparable in the number of right answers to the test when it was first administered.

The results on the second testing were compared on the basis of the mean effectiveness index obtained by each group. For the experimental group, the mean effectiveness index was 22.6, while the mean for the control group was 13.0. This difference gives a t of 5.39, which is significant at the 0.1 per-cent confidence level. In other words, the greater improvement for the experimental groups is not due to chance, but is indicative that the experimental group showed a greater increment of information than did the control group, which was not exposed to the workshop. The workshop, then, had a measurable effect on the participants.

To test the effectiveness of the workshop more completely, it was necessary to study the single items of the test on which the workshop participants showed a change between their first and second testings. This evaluation was made not only for changes from wrong to right answers, or vice versa, but also for shifts from one wrong answer to another. This approach gave an indication of the information that had confused participants, as well as what consistent errors had been produced.

[1] See *Experiments on Mass Communication*, by C. I. Hovland, A. A. Lumsdaine, and F. D. Sheffield. Princeton: Princeton University Press, 1949.

There were seven items on which the change was away from the expected correct answer, or, in other words, on which there was a loss for the group as a whole. On an additional two items, there was a very slight (statistically not significant) change in the wrong direction. Of the total of nine items on which the groups regressed, six were on the general topic of permissiveness. Upon scrutiny of the answers to these items, it was evident that there was no consistent misconception, but that the participants spread their wrong answers evenly over the available wrong choices. This was interpreted as an indication of confusion about the concept, rather than the learning of some specific incorrect answer. Thus, the workshop did not achieve its purpose with regard to the concept of permissiveness, but neither did it give a consistent misconception. The latter fact makes it difficult to assess the failure in method that made for loss of understanding, and this in turn makes it difficult to know what changes to institute for future presentations. The results lead to speculation about the importance of reaching participants soon after the workshop, to attempt to clear up the confusion before resultant misconceptions become firmly entrenched in the individuals' thinking.

On the positive side, the workshop attenders improved on 21 of the 30 items of the test. These 21 items covered all aspects of the original goals of the workshop, except the understanding of the concept of permissiveness. The most extensive improvement was found on the concepts of aggression (how to handle it and its usefulness) and identification (the child's internalization of the parent image).

Another important question about the effectiveness of workshops is: "Do people who acquire the information actually understand it and make use of it?" In the research design, no attempt was made to test whether or not participants put their knowledge into practice. Obviously, this could not be considered at the workshop, but would require some later follow-up. This difficult question needs to be studied in a reality situation with a procedure that tests individual action, but does not place too great a burden upon the workshop method. There seems to be little point in expecting one workshop on mental health to produce great changes in the behavior of the participants, and research designs set up

to test such goals probably doom the technique to failure. Hopefully, future research will more adequately answer the question of changes in action produced by any of the many mental-health-education methods.

In the meantime, in this research it was assumed that participants who could generalize the factual information they acquired to the extent that they could apply it to hypothetical situations would be more able to apply it in their relationships with children than those people who could not generalize. It is understood that personality characteristics, neurotic manifestations, and other individual differences will influence the application of information, as well as the ability to generalize. This aspect of the problem is to be discussed in a future paper, dealing with the second phase of this experiment.

To study generalization, ten problem situations covering the workshop content were depicted in the test. The participants were asked to select the one answer out of four choices that they thought most appropriate. The group improved on 9 of the 10 items, with a mean effectiveness index of 35. This indicates that the participants were able to generalize the information presented in the workshop. The one generalization item on which the group showed a loss was concerned with the use of a permissive approach in a school situation. This finding is in agreement with the results on the information items of the test.

A further comparison was made among sets of test items that covered topics introduced to the workshop by the various presentation methods. This comparison was made on the basis of the mean effectiveness index for each set of items covering each of these methods. It was found that the techniques ranked as follows: (1) the records "Dealing with Destructiveness" and "Moral Training of Children" from the *Inquiring Parent Series*; (2) a lecture on psychosexual development; (3) the film, *The Face of Youth*; and (4) a panel discussion of the pamphlet, *How to Live with Children*. However, the difference between the mean effectiveness index on the records and the lecture was not statistically significant. The panel actually resulted in a loss of correct information, although this loss was not significant and would be more correctly interpreted as no change.

It is worth noting that the records and the speech seem to be essentially the same technique, and it appears safe to conclude that lecture-type presentations are the most effective means of presenting mental-hygiene concepts regarding children. Of course, such a conclusion is valid only for these techniques used in the way they were used at this workshop. Perhaps a different procedure with the film would give a different result, although it seems probable that nearly any change in procedure with the film would necessarily be a change in the direction of a lecture-discussion type of presentation, and thus it would be following the pattern indicated as most successful by our results.

One problem in testing the effects of the workshop material is that of the immediacy of recall. Unfortunately, because of the unavailability of the audience after the close of the workshop, it was necessary to test the participants immediately after the last session of the workshop. Thus, no period for forgetting was allowed, so that it may be expected that the workshoppers tended to appear better informed at the time they were tested than they would appear at some later time. Perhaps more important, other research has demonstrated that there are "sleeper" effects from these techniques, and it is quite possible that the material may have its greatest effect on the participants' interpretations of future information acquired. Sleeper effects may also result in opinion or attitude changes, which will result in changes in practice. Some method needs to be worked out to contact workshop participants after a period of time in order to measure these important effects.

A final comparison was made of the differences in test results among the individuals who made up each resource person's group. To do this, a mean effectiveness index was computed on all items of the test for each discussion group. This made possible a comparison of the results in terms of the participants' exposure to different types of group leadership (group-oriented, authority, question-answer, leaderless). This comparison indicated that all groups showed some improvement on the test, but that the greatest improvement was made by the groups with no resource person at all—*i.e.*, the leaderless group. There were no significant differences between the other types of resource-person group.

The results were not as predicted. Study of observers' reports indicated that, by coincidence, an unofficial leader had "taken over" one leaderless group and, in that observer's opinion, had very effectively conducted a group-oriented type of discussion.[1] This does not explain why this group, which became a group-oriented section, should be superior to the groups that were designated in advance as group-oriented. No difference was found between the two leaderless groups on the test, which indicates that further study is necessary to determine the factors operating to make two groups, both designated as leaderless, but one of which coincidentally had a leader, so much alike in test results. Superficially, it appears that the answer may lie in the lack of a designated leader or "expert."

The items of the test were also grouped as those that tested information and those that tested generalization. On the information items the leaderless group remained significantly better than all others. On the other hand, the question-answer groups were the most adequate of all groups on the generalization questions. The ranks of the groups are presented in the following table:

Rank Order of Resource-Person Groups According to Improvement in Test Results

Rank	Entire test	Information test	Generalization test
1	Leaderless	Leaderless	Question-answer
2	Question-answer*	Group-oriented	Leaderless
3	Authority*	Question-answer	Authority
4	Group-oriented*	Authority	Group-oriented

* There is no significant difference between the results on the three starred groups for the entire test, although they did fall into the ranks noted.

Considering all results on resource-person methods, the indications appear to be that the group-discussion session, with a resource person included, adds little to the effectiveness of workshops, if the goal is to give information with the hope that it will lead to changes in behavior. The group discussions appear to confuse people more than they contribute to understanding, and this is especially true with the group-oriented method. However, if the purpose of the workshop is to change firmly entrenched attitudes, with resultant behavioral change, it is quite possible that this can best be

[1] One observer "sat in" on each group as a part of the second phase of the study, in which the self-oriented needs of the participants were observed.

achieved through the group-oriented discussion section, which may approximate a group-therapy situation. Research in group discussions supports this supposition. Opinion and some research in education methods support it. These results may also support it if the test results are interpreted as showing confusion among the groups with leaders, and if this confusion is considered a necessary step in changing attitudes. An adequate appraisal awaits a realistic method for determining the later behavior of those who participate in such sessions in a workshop setting.

A discussion of the results of the workshop would be incomplete without a reference to the reactions of the various resource people to their assignments as group leaders. These people were assigned to the various techniques on the assumption that they would function in a pre-planned manner, but that they would not attempt to assume a special kind of behavior or play a "rôle." An assignment to play a rôle might well have become a test of histrionic ability, rather than a test of methods of utilizing resource people effectively. The resource people were told individually how to conduct their sessions in terms of the method for handling the groups, and then an over-all view of the different approaches was discussed in a pre-workshop training meeting.

After the workshop, they were asked to comment on their group sessions and to indicate those topics which had been discussed in the group sessions. No relationship was found between the test results for participants and the topics so checked by the resource people. In fact, in most instances the groups did not discuss the general-session material in any detail, but only touched upon it in the process of considering a variety of topics more or less related to children.

A most interesting result was the anxiety that the resource people expressed about their assignments, and their confusion about the particular manner in which they were expected to function. Most of them felt that they had been forced to be authoritarian and that they had been aggressive and dominant, although the group observers indicated that this was not true in any instance. Even resource persons who were asked to act as authorities and lead the group discussion were not considered as hostile, aggressive, or authoritarian by the observers. The only people not disturbed by their

rôles were those participating in the "group-oriented" groups. On the other hand, they expressed considerable frustration over attempting to cover the material in the resource persons' manual.

The anxiety of all resource people, other than those who were group-oriented leaders, suggests that the experts have accepted the often touted argument that the best group leader is the leader who interprets, summarizes, and clarifies for his group. Many of the resource people are practicing therapists, which doubtless had some influence on their acceptance of the dicta regarding group-oriented discussion sessions. In reality, the over-all results for the workshop indicate that the use of the discussion group is at least partially dependent on the goal of the meetings, and that group discussion seems to contribute little to groups that are primarily seeking information. Other research has demonstrated this same conclusion.[1]

To summarize, in an experiment designed to test the effectiveness of the workshop method of teaching mental-health information regarding children, four techniques of presentation and four types of procedure for resource persons were investigated. A 30-item test, covering factual information and generalizations of this information, was used as a pre- and a post-workshop measuring instrument. A control group, not exposed to the workshop, was also measured by the test.

The results indicate that the workshop was an effective method, in general, for presenting this information, since the workshop participants improved significantly more than the control group in their answers to the test items. Whether or not there was enough change to warrant use of the workshop is not a problem for this research to decide. A decision to use the workshop technique would appear to be dependent not only on what might be called extraneous and situational factors, but also on the goal of the project and the relative effectiveness of all education methods that might be used to achieve this goal.

The results indicate that of four techniques (lecture, records, panel discussion, film), lecture-type presentations are

[1] See "Teaching Methods Research," by L. G. Wispé. *American Psychology*, Vol. 8, pp. 147–50, April, 1953.

the most effective means for imparting mental-health information. Records from the *Inquiring Parent Series* and a lecture on psychosexual development produced the greatest increment of information in the workshop group.

With regard to the type of leadership given by resource people in small discussion groups, it was found that the leaderless group gained the most on test results. This indicates that for presenting information, at least, the resource person in a small discussion group adds little to the workshop's effectiveness. It would be interesting, in view of these results, to have a measure of workshop participants' increment of information when they had not been members of any small group.

A measure of change in child-rearing practices is not covered in this study, and answers regarding this all-important indication of the effectiveness of the workshop technique await future research. However, in an effort to study the degree to which participants understood the material they learned and might be able to apply it, questions were structured in the pre- and the post-workshop tests to measure capacity to generalize. The results indicate that members of the workshop were readily able to generalize from the content of the material presented, and this suggests that these individuals will be able to utilize what they learned if there are no reasons, personal or otherwise, that counteract this ability.

THE LIBRARY AS A CHANNEL FOR MENTAL-HEALTH EDUCATION

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STAFF members of child-guidance centers and mental-hygiene clinics receive frequent requests for information on mental-hygiene subjects. These requests come from a wide variety of persons, such as teachers, parents, nurses, social workers, P.T.A. and mothers' clubs, church groups, and others interested in the welfare of the people of the community.

The information may be sought to meet personal needs, as in the case of a mother who wants to ask questions about a feeding problem, the teen-ager who wants help in learning about careers, or the teacher who is interested in suggestions for dealing with the "classroom cut-up"; or it may be sought by organized groups, such as school systems that want help in program planning, informally organized groups of parents who request information about child development, or church groups who come asking for materials to help them in working through such knotty problems as educating children about sex and death.

Clinics meet these requests as well as they can. However, the end result is all too often that some staff member finds himself talking to a group on a subject that may be of interest to only a small fraction of the people present. At other times the staff may recommend suitable pamphlet materials, but have difficulty in obtaining them immediately. A suitable film may be recommended, but some one to comment on the film is usually necessary. Without underestimating the value of these procedures, it is obvious that only a small part of the demand can be met through such efforts. There are limitations in time, effort, and available funds.

An attempt to meet some of the needs described above has been made in a community child-guidance clinic in Wisconsin.[1] This effort is described below.

[1] La Crosse County Child Guidance Clinic.

A sample list of materials was devised. They were designed to meet the requests most frequently made. They concerned such topics as "juvenile delinquency," "sex education," and "special problems of young children." Since most problems can be approached from more than one point of view, an attempt was made to give the reader a comprehensive survey of the problem. This was done by arranging sets of pamphlets relevant to a given problem instead of offering a single pamphlet as a magic solution of it.

This procedure has several advantages. For example, more has been published about some topics than about others and various publications emphasize different aspects of a certain problem. A given booklet, such as the Children's Bureau publication, *Your Child From One to Six,* may treat a number of common problems. Such booklets deal with other subjects, too, and it is desirable for the reader to become interested in some of these other topics because it will help him to understand better the concept of the problem as a part of the individual's total personality rather than an isolated problem.

Pamphlet materials currently available were explored and a series of pamphlet sets were planned. These sets were arranged on the 15 specific topics that seem to be of greatest interest to the public. It was hoped that through a systematic evaluation of these materials, a reëvaluation of the entire list could be made later. Titles for the 15 sets are: *Angry Children; Baby (And You); Careers (Helping the Student Choose); Children in Trouble (Conflict With Authority); Dating (and Preparation for Marriage); The Family (Your Children and You); Feeding Children; Handicapped Children (And Their Problems); Jealousy and Competition (Children With Other Children); Pre-School Schooling; Sex Education (Answering Children's Questions); Sleep; Speech; Teaching Aids (The Children and You);* and *Young Children.*

It was felt that the materials should be got into the hands of interested persons in a convenient way, and for this the cooperation of local librarians was obtained.[1] It was decided

[1] The author wishes to express her appreciation to Miss Muriel Fuller and Miss Gertrude Thurow, of the La Crosse Public Libraries, and Mrs. Edna Schaller, of La Crosse County Library, for their help on this project.

that the 15 sets would be placed in the local libraries for the general public to check out like library books.

Many libraries throughout the country have such pamphlet material available, but presenting these materials in organized sets that have been gathered and screened to fit local needs seems to have special advantages. One of the first and most obvious is the opportunity to reach a much wider group of persons than would come to a mental-hygiene clinic. The library facilities reach more persons and a wider cross-section of the population. Although the staffs of clinics try to represent the clinic to the public as a source of help to which no stigma is attached, many persons are still reluctant to go to a psychiatric clinic. Consequently, we might expect many persons who would be unlikely to go to a clinic to be exposed to such literature in the library. This also applies to students who go to the library in connection with their studies. A person trained in library techniques can handle the process of distribution of materials more efficiently than members of a clinic staff. Further, the acquisitions of a public library are regularly publicized. By working in coöperation with the public libraries it was possible to (1) reach a larger number and variety of persons; (2) reach persons who would hesitate to go to a psychiatric clinic even though they need information; (3) distribute materials more efficiently; and (4) publicize material more readily.

In Wisconsin the state board of health makes available to the public publications on mental-health subjects and child guidance. Some of these are published by the child-guidance division of the section on maternal and child health of the state board of health. Others are pamphlets published by the Children's Bureau of the United States Department of Health, Education, and Welfare; the Science Research Associates; the Public Affairs Committee, Inc.; The Health Publications Institute, Inc.; The Canadian Department of National Health and Welfare; The Child Study Association of America; and others. (Materials could be acquired from these sources directly by clinic personnel in other states.) Many of the materials used in this project were furnished by the Wisconsin State Board of Health. A number of pamphlets for use in this series were also purchased by the clinic. All materials

were, of course, carefully studied and evaluated by the author before inclusion in the series.

Another service of the Wisconsin State Board of Health is the large film library on mental-health subjects. Film discussion guides, with explanations and discussion questions for each film, have been made up by the child-guidance division. Films are available without cost to residents of the state. A list of films pertinent to the specific topic and the discussion guides for these films were included in the 15 sets of pamphlets. These guides actually contain a rather complete discussion of the mental-health subject illustrated in the film.

The need to present the materials in attractive fashion was considered. Obviously, the materials would have more appeal to the persons we were trying to reach if done up in an eye-catching package. Therefore, folders in pastel colors were selected to hold the pamphlets. These folders were of the type available in office-supply stores; they were approximately 9″ x 12″ and contained pockets on each side. Some durability and convenience were sacrificed in these folders for the sake of attractiveness. It was felt that this was a justifiable loss, since there would be little point in offering even the most durable materials if nobody found them attractive enough to open.

The front of the pockets contained brief explanations of the project. The side containing the film discussion guides read:

> "These leaflets describe some films pertinent to the problem. These films are available without charge (except return postage) from the Wisconsin State Board of Health. Films should be requested about one month before they are to be shown. A complete list of the State Board of Health Mental Health films is available at the library and from the La Crosse County Child Guidance Clinic. Consult the librarian about other films."

The pocket containing pamphlet materials had the following inscription:

> "These materials were selected and placed in the library by the La Crosse County Child Guidance Clinic as a service to the community. Please check the folder to see that all units are replaced after use."

Listed below were the titles of the pamphlets for that set.

The title of the set and the library data were typed on colored slips and mounted on the front of a folder.

The librarians agreed to help evaluate the project. There-

fore, there was placed in each set, as it was checked out, an "evaluation slip." This slip was intended to give data on the amount and type of use the materials got, to get comments on the project, and to learn what the public would like to see added to the set. These slips read as follows:

> "In order that we may make this service more valuable to those using it, we would appreciate your filling out this blank.
>
> Name of set used:
>
> Please check if you are: Parent—Grade School Teacher—High School Teacher—College Teacher—High School Student—College Student—Social Worker—Other.
>
> Number of people using materials:
>
> Use materials were put to:
>
> Did you order or plan to order films?
>
> Comments:"

The librarians took the responsibility, also, for publicizing the project. This seemed to us an important point, since it was a new project in this county and unless the public was informed of their existence, the sets would gather dust on the shelves. Radio and newspaper publicity was given to the project in the county. The libraries also staged exhibits of the sets to promote interest in them. Immediately after they were placed on exhibit, the librarians began to get questions about where the individual pamphlets could be obtained for permanent use. Therefore, cards listing those materials that could be obtained without charge from the state board of health were placed with the exhibit.

The public seemed to like the idea. The clinic staff received many favorable comments from persons who had seen the exhibits and used the sets. Some of the sets were checked out immediately. A survey made three months after the sets had been placed in the libraries showed that in each of the five libraries there had been 12 or more check-outs. Further, it was shown that only about 35 per cent of the persons checking out the materials filled out the evaluation slips. All of those who filled out slips were parents except two who were teachers.

Comments on the project showed that users were favorably impressed by it and planned to use films for personal and group use. The librarians reported that they had kept the materials on display as much as possible. Many parents who brought their children to the library story hour would

pick up a set and read portions of it while they waited for their children. The preliminary evaluation, therefore, shows that the project was well received.

This type of community education in mental health seems to have many possibilities. The advantages of reaching a wider audience more effectively were outlined above. It seems to us that there is an additional advantage in offering materials, but leaving each individual free choice of selection. It might be assumed that the materials will gain their greatest use by persons who have questions they want answered and these persons are psychologically in a better position to accept the information they are offered. They are not required to agree with the concepts presented, but can read about the views of various authorities, discuss the points with others, and become stimulated to think the matter through.

The possibility of using similar sets of materials in a smaller community in which no mental-health resources are available seems worth investigating. There is probably a real need in many of these communities for further mental-health education. Obviously, some one who is familiar with the field of mental health would be required to evaluate the materials in order to avoid distributing misinformation, outdated information, and materials that are potentially harmful emotionally. Perhaps small local libraries would be able to get help from the personnel of their state mental-health authority or mental-health association.

Many local libraries to-day have film services. Many state universities and other large universities have huge film rental libraries available. Therefore, a list of available films could be made up to fit the particular community resources.

In conclusion, we feel that our experience with this project has demonstrated that the public is interested in and receptive to further mental-health education through the medium of professionally organized sets of mental-health publications made available to them in public libraries.

UNIQUE FUNCTIONS OF PUBLIC-SCHOOL GUIDANCE PROGRAMS

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IN any community, many different kinds of agency are concerned with the treatment of emotionally disturbed individuals and families. It seems self-evident that some kinds of treatment could be attempted under essentially the same conditions in any one of several agencies. Other kinds of treatment are less transferable; the external or internal circumstances of a person's life make him "treatable" at one level or by one kind of agency and not accessible to treatment under different conditions.

To cite a somewhat irrelevant example to achieve a clear illustration, a prisoner locked up in jail is usually not free to seek help from outside community agencies. Moreover, attempts at treatment must be adapted, not only to the prisoner's previous psychological needs, but also to the milieu and to the practical and emotional circumstances of being imprisoned.

These comments seem to make much of the obvious. Yet the general field of "mental health"—especially when preventive or prophylactic efforts are included—is so large and so complicated, so susceptible to generalizations, and so apt to be further confused by our pious hopes, that it seems important to be concrete, even at the risk of seeming simple-minded.

First, then, why do we have several different kinds of agency in a community? What reasons of history, circumstance, expediency, community planning, functional and conceptual differences, and so on justified the diversity? I do not intend to answer this question, but rather to use it as a springboard for my more limited thesis, which is concerned with agency function only in the area of treatment and prevention of psychological disturbances. I realize that this forcible wrenching of the psyche out of the body, the family, the community, the culture and circumstance does

violence to the facts; however, I am talking about the point of contact with the individual, not about all the variables in his difficulties.

The thesis to be discussed in this paper is as follows:

1. *Many different kinds of agency are necessary in a community if the psychological needs of various individuals are to be met.* Our prototype of the patient or client too frequently ignores problems of "motivation" and "treatability." We, therefore, may think too exclusively of adding facilities—especially conventional treatment facilities—without taking into account the realistic fact that the majority of emotionally disturbed people are not treatable, or are not best treated, in this type of situation. There are two aspects to this. Treatability depends, first, on the way in which the person sees himself and his problem. Secondly, the agency makes a decision about the level and kind of treatment that seems most helpful, and the criteria for helpfulness must include *not* making a bad matter worse, as well as attempting to improve it. If a hypochondriacal patient is warding off psychotic disruption by his preoccupation with physical symptoms, treatment planning must take the former into account as well as the latter.

2. Not only are many different kinds of agency necessary to meet the needs of various individuals, but *certain agencies have non-transferable functions*—functions that rise out of their unique position and that cannot be duplicated by other agencies. I am calling this the area of *unique function* and contrasting it with the *transferable or optional functions* which could, presumably, be performed by any one of several agencies.

The unique functions of an agency usually involve both difficulties and advantages. Consider, for instance, the complicated relationship between a probation worker and his legally determined client. However, in this paper, I am primarily interested in discussing the implications of the fact that, to continue with my example, only the probation worker has any chance to treat certain individuals. For instance, those probationers who do not agree with the community about the nature of their problems or needs would not seek help in another kind of agency, or could establish confidence

in a relationship only if they were forcibly detained long enough to experience it.

3. In this paper a public-school guidance department will be discussed largely in terms of its unique functions—those that could not be transferred to any other agency. The fact that there is an area of unique function in public-school guidance stems from the fact that the law requires parents to send their children to school. A child whose parent was "motivated" to send him for treatment in the usual psychiatric sense could be treated either in a public-school guidance clinic, if orthodox treatment were available, or in another community agency. This kind of case falls into the area of transferable function. Other children, however, may show evidence of emotional disturbance in the classroom and be referred by teachers, or parents may ask for help of various kinds aside from treatment. The very fact that children have to go to school means that problems of child and parent are exposed to observation and reference without the presumption of "motivation" in the orthodox sense. In other words, many of these children and parents do not see their needs or problems in a way that could enable them to seek or to get help from a voluntary treatment agency.

To avoid innumerable qualifying clauses and quotation marks, let me specify the following usage in this paper: "treatment" refers to private or agency psychotherapy and case-work of various kinds and levels. It includes the therapeutic endeavors of psychiatrists, social workers, and psychologists. The terms, "psychiatric," "psychological," and "emotional," to designate disturbances or treatment, are used interchangeably. "Motivation" and "treatability" I am defining simply as (1) the way in which a person sees himself, his needs, and his problems, consciously and unconsciously; (2) the levels and ways in which he is willing or able to tackle them; and (3) the level and method of treatment that seems most useful and least dangerous, in the opinion of the person who treats, guides, or counsels him.

Public-school guidance, in its area of unique function, is not a diluted version of psychotherapy. It encompasses (1) an overlapping, but larger field, and (2) a characteristically different, though also overlapping, set of techniques. Essentially, though both disciplines utilize the same theoretical

rationale and work to achieve results along the same general axis, they differ in technique or applied skills as well as in the person they are optimally able to treat.

The practical implications of this viewpoint can best be illustrated by discussing a public-school guidance department, in Oakland, California, in which the philosophy and development have centered largely around unique guidance functions and in which there is a minimum of optional or transferable function—*i.e.,* cases are referred to other community agencies as soon as such reference is possible.

A guidance department organized around such a philosophy stands between the extremes of two historic trends: (1) that which conceives the function of public-school guidance to be primarily the development of a treatment clinic similar to any other treatment agency, and (2) that which feels that guidance should concern itself largely with in-service training of teachers, participation in curriculum planning, and so on. In this second view, work with individual children is considered to be an extravagant and ineffectual method for influencing all-over public-school attitudes and practices in the area of mental health.

These two views correspond roughly to the "centrifugal" and "centripetal" schools of thought.[1] The former tend to remove disturbed children from the classroom in order to treat them in a centrally located clinic with techniques similar to those of any more or less orthodox child-guidance clinic. The latter, or centripetal departments, are so organized that workers have their offices in the various schools and center their activities largely around work with teachers or work with children in areas that more nearly approach instructional areas—*e.g.,* special work with children who have reading disabilities.

History and Structure of the Department of Individual Guidance of the Oakland Public Schools.[2]—This department is one of several dealing with pupil personnel services that make up the division of special services, under the supervision

[1] See "Centrifugal and Centripetal Guidance Programs," by Esther Lloyd-Jones. *Teachers' College Record,* Vol. 51, pp. 7–13, October, 1949.

[2] I am indebted for the writing of this section, and for collaboration and counsel on the whole paper, to Miss Marion Clark, Coördinator, Department of Individual Guidance and Attendance, Oakland Public Schools.

of an assistant superintendent in charge of adult education and special services. Other departments are those of attendance, health services, occupational adjustment, and special education. The programs of the various departments are coördinated by the assistant superintendent, and services to individual pupils are coördinated by the maintenance of a single record office for all departments and the use of a single record for each child for whom any special central-office services are rendered.

The staff of the department of individual guidance consists of eight consultants in individual guidance, a part-time consulting psychiatrist, and a coördinator. The consultants are selected for special training and experience in child development and child psychology. They are drawn from three backgrounds of training and experience: clinical psychology, educational psychology, and social work. All have had classroom-teaching experience. It is felt that there is a sharing of viewpoint and experience in drawing from the three backgrounds that is mutually useful to staff members. The advantage of classroom experience in work with teachers is obvious.

The program in individual guidance was organized in 1933.[1] From the beginning, the service has been a "consultant" service, available to schools whose principals wished it. It has had a twofold purpose: to assist children who showed maladjustment at school and to help teachers to a better understanding of these children and all children. Originally, and with a smaller staff, consultants called at schools in answer to requests for help with specific pupils. Then a regular visiting schedule was offered to principals who wished it. To-day, nearly every principal asks for regular time. Although the staff has been increased to eight consultants, the demand for service has increased beyond what can be met. Because it seemed logical to give more help at the elementary level, service to high schools was curtailed.

Oakland, at the present time, has 82 schools (not including adult): 64 elementary, 13 junior high, and 5 senior high, with a total school population of 55,600. All secondary schools

[1] From 1933 to 1946 the program was under the supervision and leadership of Herbert R. Stolz, M.D.

receive special help from one consultant whose responsibility is follow-up on placement and school adjustment of boys who are under the supervision of the juvenile court or the Youth Authority. All elementary and junior-high schools may request either regularly scheduled time or help in special cases. Almost all choose the former.

Where a consultant visits a school on schedule, he or she works closely with the principal or vice principal and also comes to know the teachers. Many informal conferences are held with teachers about pupils, about class group behavior, about promoting good mental health in the classroom. When a teacher wants advice on an individual pupil about whose behavior or adjustment or achievement he or she feels concern, a form requesting this special service is sent in to the central office through the principal. The consultant's service in such cases may range from observation of the child and conferences with the teacher to interviews with the child; conferences with teacher, school nurse, elementary assistant, and other school personnel who know the child; conferences with parents; arranging for special psychological tests; consultation with school psychiatrist, where indicated; possibly arranging for referring the case for family case-work or psychiatric treatment; and long-term contact with the family until such reference is useful.

Operation of the Department.—The basic clinical focus is on the teacher-pupil relationship. This means that emotional energy for change is provided through the individual relationship of the guidance worker with teacher, student, or parent or all three. The dynamic impetus for personality change is derived from the use of technical skills in an individual relationship with an anxious person. However, this activity is carried on in the setting of the school and classroom. The child is usually seen there; there is general acquaintance with the methods, attitudes, and anxieties of particular schools and particular classrooms; and the work is immediately integrated through the principal.

It is felt that an approach centering in work with individuals in this setting does more than assist in the psychological progress of a given child. The particular anxieties roused in the teacher by the child's behavior are also part of the core focus. Through working with the teacher directly

—*e.g.*, through her increased understanding of the child's problem and how it resonates for her—as well as indirectly—*e.g.*, through the reduction of teacher's anxiety because of work with the child and, hopefully, his improvement—an emotionally charged in-service training program is set into effect. The reduction of anxiety and the insights gained through collaboration on the problems of one child result in more relaxed and insightful handling of other children in present and future classrooms. The irradiation to other children in the classroom and the carry-over of change in the teacher are not theoretical suppositions; they have, in actual fact, been one of the most striking results of this philosophy and method.

It seems prudent to stress the emphatic difference between this approach and in-service training of a more academic or impersonal kind, in which lectures, discussions, and so forth, often using case material, are held with groups of teachers. Valuable as the latter approach may be, in its appropriate place, it is not a substitute. On the contrary, indeed, the core function of the guidance worker begins where the "academic" program ends—that is, where anxiety (on the part of child, teacher, and so on) prevents his understanding and utilization of educational material. The guidance worker is primarily concerned with the dynamically rooted functional change that can be accomplished through the use of technical insights and skills in an individual relationship with an anxious person.

Guidance and Treatment.—What are the differences between this approach and the orthodox treatment?

1. It is not theoretically impossible, but practically it is very difficult to develop a dynamically meaningful relationship with a teacher when he is not an active collaborator in assisting the child. Yet he cannot collaborate in an immediate, mutual sense when the child is taken out of the psychological and geographical boundaries of the classroom and school for this treatment.

2. In the orthodox treatment situation, the child's and (especially) the parents' motivation is a hurdle to treatment or sets the limits of treatability. In the simplest sense, this means that a parent has to be willing, for instance, to bring or to send the child to the clinic regularly for his therapeutic

sessions and usually to participate himself on some level. In the guidance program, on the other hand, within practical limits, no case should be rejected as unmotivated. Motivation is equally important, but it influences method and treatment goals rather than the fact of treatment.

A child is referred because his behavior in school disturbs some one. The parents often do not see the problem in the same way, nor are they necessarily concerned about the same problem; hence they may lack motivation for treatment in the usual sense. None the less, one would assume that the parents of a disturbed child have some conscious or unconscious area of anxiety or difficulty. The technical problem of the guidance worker, then, is to perceive what the parent *is* anxious about and to start from that point. The philosophy or theoretical background and treatment axis or direction are the same; the technical skills comprise a highly specialized, applied branch of technique.

An example may clarify this distinction. It is a rare junior-high-school student who can make use of the bald and demanding atmosphere of the orthodox treatment situation, in which he is expected to formulate his problems and to discuss them in so many words with the explicit aim of clarifying inner conflicts. Nor is it always theoretically desirable that he should do so. Yet a person generically related to his school environment, who can demonstrate a desire to be useful through program adjustment or mediation with authority, for instance, may gradually be able to establish a relationship of trust that will enable the student to recognize inner sources of difficulty and give him hope of improved function through understanding them.

To summarize, public-school guidance enters the picture when a child is referred because his behavior (usually in school) disturbs some one. His presence in school, hence his being referred, derives directly from the compulsory-school law and not from a given attitude toward the problem or motivation. The attitude of child, parents, and teacher toward the problem are crucial, not in estimating treatability, as in a conventional treatment situation, but in determining the point of departure in meeting the problem and the techniques that are appropriate.

It should be apparent from this discussion that guidance is not diluted psychiatric treatment, but a specialty, embodying the same theoretical concepts with its own singular technical skills. In the case of a child with a reading disability, for instance, a psychiatrist would focus on the dynamic problem and hope, through treatment, to alter the cannibalistic fantasies, say, that disrupted the child's efforts to perceive letters in a neutral, realistic way and hence to learn to read them. A guidance worker, on the other hand, might be concerned with a different kind of diagnostic evaluation.

For example, a group of children who often have trouble with reading are passive, docile boys, often enuretic, with mothers who are superficially feminine, but covertly domineering, and fathers who are "hyper-masculine" as a defense against their own passivity problems and who are greatly disappointed if their sons are not athletic "he-men." Attempts to remedy the reading difficulty at the elementary-school level (short of psychotherapy) are often unsuccessful. Yet, in junior-high school, these boys may show a change in behavior: they become suddenly rebellious instead of docile, often giving up the enuresis at the same time. If the rebelliousness is not too severely suppressed and if a suitable tutor is used, they may now quite rapidly learn to read. The tutor of choice is a man who is relatively nonaggressive, but has accepted and integrated his passivity; he serves as a bridge or alternative between the extreme polarity of the parents.

In addition to these differences in technique, the field of guidance is broader than the orthodox field of psychotherapy. It encompasses also in its everyday function many socioeconomic problems; knowledge of community resources; school structure, function, and demands; instructional problems and participation in curriculum planning; and so on.

Complementary School Programs.—One of the perplexing methodological and practical problems involved is the extensiveness of the need for guidance services in a public-school system of any size. One is faced with the unattractive alternatives of increasing guidance staffs to monstrous (and self-defeating) proportions or of offering highly amputated services.

It has been felt in Oakland that the centrally based and administered guidance program should be kept relatively small in order to preserve coherence of philosophy and flexibility of operation. Yet, though a guidance worker is involved in trying to "work himself out of a job," the reverse seems to take place; demands on his time increase as the school personnel become more perceptive and more trustful. The nature of the demand shifts, however, as teachers develop more insight and, at the same time, are better able themselves to handle problems they previously referred. For instance, guidance departments that have operated over a period of years share the common experience of a shift to a preponderance of requests for help with children whose symptoms are less socially disruptive, but often psychologically more urgent—*e.g.*, phobias, withdrawn children, and so on.

These facts suggest one possible solution to the problems of increasing services to emotionally disturbed children without diluting the guidance department beyond recognition or developing a behemoth that would defeat flexible function: namely, the organization and training of workers in certain areas that previously had been within guidance or that straddle between guidance and instruction.

Oakland has developed such an idea in the elementary-assistant program. Conceived and organized by members of the administrative, instructional, and guidance staffs,[1] it operates in the elementary schools. A group of highly skilled teachers, who were mature individuals and well accepted by their colleagues, were taken out of their classrooms and assigned half-time to each of two schools—one, the original school in which the individual had taught; the other, a school in which she felt she could work effectively (her choice being limited by administrative necessity and practical circumstance). This program was offered as an optional service which principals were free to request, but under no pressure to accept (the latter being especially guaranteed by the fact that there were too few elementary assistants to go around).

The elementary assistant functions flexibly, depending on

[1] This program, during its formative years, was supervised by Miss Irean Coyner, Supervisor in Instruction, Oakland Public Schools.

the needs, demands, and "readiness" or sensitivity of a given school. However, her core function is to assist with the effective handling of learning problems through work with individuals or small groups of students who are having learning difficulties, and, in addition, to work with teachers through providing special materials, counseling on methods, and so on. Most of the formal activities of the elementary assistant are instructional, but it can easily be seen once more that the dynamic impetus that makes change possible occurs in the framework of her therapeutic relationship with individuals and does not derive from passing on information alone. There are many children whose learning difficulties cannot be overcome in a classroom, no matter how skillful and patient the teacher or how excellent the curriculum. These children can be helped only in an individual —or, at times, a small-group—relationship.

Often the activities of the elementary assistant may resemble those of the child therapist. Some children must spend weeks or months with paints and materials, using them in a classically "psychotherapeutic" way, or developing confidence in the relationship, or testing it out, before any direct steps can be taken to tackle the learning difficulties.

There is, however, a crucial difference between a child therapist or guidance worker and an elementary assistant—*viz,* the purpose or aim for which the relationship is used. In the former case, the goal of the relationship is to increase understanding of emotional conflicts and to assist, in so far as possible, in their successful resolution. Indirectly, this might enable a child to learn more effectively, but the technical skills are focused on the emotional conflict. Just the reverse is true in the case of the elementary assistant. The goal of the relationship here is to make learning possible. Indirectly, the child may work out emotional problems that are not immediately related to the learning difficulties, but this is a by-product.

The elementary assistant is not a diluted guidance worker. There is a careful differentiation of rôle and function between the two. The elementary assistant utilizes the relationship, material, toys, and so on, in a sensitive and (broadly) therapeutic way just as any wise and experienced person may do.

We would all agree that therapeutic changes in people are by no means limited to official treatment relationships. However, the technical training of the elementary assistant is primarily in instruction and the therapeutic relationship is subordinate to this end, not utilized for interpretative or other explicitly psychotherapeutic purposes. Obviously, a program of this kind would contain serious limitations and hazards were it to lack the diagnostic and collaborative work of guidance, or if poorly selected personnel misconstrued their rôle to be that of amateur psychiatrists.

A program of this kind complements the guidance program in a remarkably effective way. There can be close collaboration in a school on respective rôles in a given situation and on the most appropriate level on which to approach a problem at a given time. The two programs are mutually enriching. Moreover, the elementary-assistant program covers an area that otherwise would fall, to some extent, under the ægis of guidance, and provides a group of people more explicitly trained and skilled in that area than one could assume a group of guidance workers to be.

It provides the additional advantage of a group of mediators, interpreters, and friends of the guidance philosophy operating in schools as familiar members of the faculty group and respected fellow teachers. Moreover, because of this integration into the school, the elementary assistant is able to form a relationship with many teachers who are not "ready" to accept a guidance worker, thus extending the total range of the program in yet another way.

The Oakland Guidance Department has felt a school guidance program, in its total aspect, to be more strengthened by the development of the elementary-assistant program—and, potentially, other programs similarly conceived—than it would have been by the indefinite multiplication of guidance-department personnel.

Community Organization.—Several times in this paper I have referred to guidance as a field whose unique functions differ from those of orthodox treatment. In the orderly development of community resources, the concept of unique and transferable agency function should be kept in mind. As we have said, the unique function of public-school guidance

stems from the law which says that children have to go to school. This means that a child may be referred to a guidance department long before he or his parents see their problems in a light that would motivate them to seek treatment in a community agency. (Over 80 per cent of the Oakland Guidance Department cases fall into this category.)

Other community agencies also have unique functions. The juvenile-probation office usually becomes involved in problems, not because the person is "ready" for treatment, but because he commits an illegal act and gets caught. A well-baby clinic sees parents who bring in their children for reasons that are not officially psychological at all. There may be important emotional components in the problem, none the less, and if the person is not "ready" to be referred successfully to a treatment agency, the well-baby clinic must serve a unique function analogous to that of school guidance (assuming that they understand the advantages and difficulties in their area of unique function and develop the appropriate technical skills).

We should, therefore, summarize the unique function of an agency as a function that cannot be performed by any one else. It is a generic function of the given agency and non-transferable. Optional or transferable function is work that could theoretically be undertaken by one of several agencies. A public-school guidance program might encompass orthodox child-treatment facilities. In contrast to the guidance activities described in this paper, however, such treatment facilities would comprise a transferable or optional function for public-school guidance.

It should not be necessary to add that the fact of unique or transferable function has nothing to do with the value of either function to the individual or to the community. The only practical problem involved in the amalgamation of the optional-treatment function and the unique-guidance function in the same organization lies in the common human tendency to permit the more orthodox, better channeled, more easily conceptualized aspect of the program—namely, the formal treatment—to encroach upon and eventually to overrun the other.

There is an additional circumstantial problem in communities in which treatment facilities for children are so inade-

quate that there is a perennial temptation to start the major child-guidance clinic for the community in the public schools. The basis for this, presumably, is the hope of financing such a program before members of the community are ready or able to finance it. This is a tempting solution to a frustrating situation, but it would seem open to grave question. The numbers of people excluded or with less access to such a clinic should be kept in mind: pre-school children, certain (slowly maturing) children who do not enter school till seven, children in private and parochial schools, people who drop out of school to work at sixteen, and so on. In addition, it seems undesirable to set up a clinic for children that could not be closely integrated with a treatment program for adults.

What does this mean in terms of community organization? It seems that there should be careful analysis of community agencies with unique functions. The effective development of total mental-health and treatment facilities is contingent on the inclusion of these agencies in all planning, enlargement, and improvement of resources. Special training programs are badly needed for the specialized skills involved. We all realize that one of the most important (and perplexing) problems in this area is that of treatability or motivation—so much more sharply limited than need for treatment in abstract terms. Agencies with unique functions like those described above provide one of our most important ways of extending the range of psychological treatability, which no simple pyramiding of treatment agencies and psychiatrists will do. Both kinds of facility must develop together for the extension and improvement of community resources in the area of mental health.

THE USE OF MASKS AS AN ADJUNCT TO RÔLE-PLAYING

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ALTHOUGH a great deal has been made of masks in primitive societies—where, for example, the witch doctor is supposedly endowed with formidable powers when he dons his mask and acts the character that the mask is supposed to represent—in our culture, masks are identified mainly with Halloween, occasionally with a fancy-dress ball, or with art projects in which a child makes a mask, but does not often use it actively in playing a rôle. And yet invariably a child or an adult who dons a mask begins spontaneously to act out some sort of rôle, which he believes to be related to the character suggested by the mask. This spontaneous acting, though usually brief and undirected, seems to provide amusement for the actor as well as for the audience.

The present study is concerned with the use of masks in directed rôle-playing such as occurs in socio-drama and psychodrama. The current clinical interest in rôle-playing has made little use as yet of the possibilities of masks as an adjunct. While puppets, projective playing with dolls, sociodrama, and so on give valuable information as to personality structure and provide therapeutic opportunities for projecting and "acting-out" personality problems, it seems to us that the use of masks adds an additional dimension. Through their use the child can more clearly identify with the rôle he wishes to play, and he can, through identification, more clearly establish the fact that it is possible to change rôles. For the child who has a negative self-image, the opportunity to test out different rôles offers tempting possibilities. Hiding behind a false face somehow gives the wearer an illusion that he himself is covered and, therefore, that his ego is not responsible for the antics of the new character.

It was the goal of this study to accelerate the testing out and adoption of new rôles through the use of masks in spontaneous rôle-playing.

We chose for study a group of children who had been referred to the speech correctionist for "stuttering." We felt that the use of masks in rôle-playing would have an additional clinical interest in association with these children. It has been shown that children afflicted with speech blockage often show no signs of their disturbance when they participate in a play in which they are called upon to speak memorized lines, especially if they are portraying some other person. It has also been observed that individuals afflicted with "stuttering" often have no difficulty at all in singing. In as much as spontaneous rôle-playing with stutterers has been used with positive results, we were concerned primarily with the effectiveness of the masks in rôle-playing.

Since this study was exploratory in nature and we were interested in observing as closely as possible the children's reactions to the use of masks in spontaneous rôle-playing, no variables were controlled. It may be, therefore, that the behavioral changes that resulted could have been due to variables other than the introduction of masks into the spontaneous rôle-playing situation.

The group with which we worked consisted of five boys, four Negro and one white, aged between eight and eleven years, who attended speech class once a week for ten sessions. The children met during the last period before lunch. They were invited to bring their lunches and to remain in school during the lunch period. As the lunch-period part of the program was voluntary, all of the children were not always present. Their absence was apparently not by choice since it was not uncommon to have a child run all the way home to eat his lunch and run all the way back to join the group.

In addition to rôle-playing, the program consisted of discussions, occasionally drawing, spontaneous "talent shows," and training in relaxation. Recordings were made during the rôle-playing sessions, and these recordings were usually played back during the luncheon period.

Throughout the ten sessions, an atmosphere of democracy prevailed. The examiners would start the session with a dis-

cussion of some emotionally "loaded" topic. From this the children evolved, with guidance, a rôle-playing situation.

As the children grew more familiar with the procedure, they were urged to present topics for discussion. There seems to be no doubt that Speech Class became an extremely important experience for them. Teachers reported that the children watched the clock carefully on meeting days. There were never any absences. One child, for example, insisted that his mother send him to school so that he would not miss "Speech." By the end of the session, it was discovered that he had been suffering from a severe earache and had to be sent home. At the last meeting of the school year, the children expressed great disappointment at the termination of Speech Class and begged for "just one more meeting."

Throughout the program the children's speech difficulty was discussed with them and group exchange was frequent on such topics as "Why doesn't our speech block when we wear masks?"

When the children were first introduced to the masks, they were told: "Instead of having your usual speech lesson to-day, we thought that you might have fun developing your own shows. Here are some masks that might suggest to you some of the things you'd like to play."

The children immediately showed an interest in the masks and a few minutes later, with a minimum of guidance from the psychologist, they began spontaneously to portray a scene in which the school principal delivered a "bad" child into the hands of his father. The scene was played with considerable gusto, and not once did any of the children show evidence of speech blockage. Even a child with an extraordinarily severe stuttering handicap assumed the rôle with complete freedom from blockage.

It was interesting to note that when the children lifted the masks momentarily to ask questions, and hence to assume their own rôles, the stuttering reappeared. On subsequent meetings we discovered that the wearing of a mask and the assumption of a rôle did not necessarily mean the disappearance of blockage. It seemed to us that the degree of absorption the child had in the rôle, coupled with the factor of personal significance that the rôle had for him, determined the amount of blockage. For example, almost every

child stuttered severely when asked to portray the "biggest boss in my life."

One of the striking features observed in the rôle-playing of these children was the remarkable change that occurred in bodily movements. In observing the children playing rôles with and without masks, we felt that the changes that took place in bodily movements while the children were wearing masks was an index of the effectiveness of the use of masks. One child, for example, when playing the rôle of an authoritarian figure and using a mask, banged his fists and jumped up and down, stamping his feet as we had never seen him do without the mask.

At the first three meetings, the children seemed to enjoy the masks greatly. They were encouraged to look at themselves in the mirror while wearing masks, so as to establish more clearly the identification they were making with a new rôle. At the fourth meeting, two of the children announced spontaneously that they no longer needed the masks and felt that they could do just as well without them. From this point on, the children used the masks sporadically and inconsistently. At the seventh meeting, they discussed the use of masks, saying that they were "too hot and stuffy, and smelled bad." Occasionally at the last three meetings, a child would choose to play his rôle with the aid of a mask, but on the whole they preferred to proceed without the masks.

It should be pointed out that the masks used were representative of everyday people rather than "story-book" characters or familiar radio figures like "Howdy-Doody," and so on. The masks we used could be easily identified with parents, teachers, and siblings. They all represented white people, and as we were working with a group of predominately Negro children, it is not known what effect the color factor may have had in rôle-identification. The children never commented upon the fact that the masks represented white people, and it was our impression that the factor of color was probably unimportant.

At the end of the first session, the children were asked if there were any masks not represented in our supply that they thought would be useful additions, or if there was any mask in our selection that they liked particularly. Only one

child spoke up. He selected from the masks the most strongly authoritarian figure (a male with black beard and hair and large black spectacles) and announced, "This is *my* mask!" Throughout the rest of the sessions, this child always chose the authoritarian mask. After the close of school, the experimenters noticed that this particular mask was missing. A look around the room disclosed the mask stuffed far in the back of one of the drawers in the teacher's desk.

One great advantage in using masks as an adjunct to rôle-playing lies in the fact that they seem to make the adoption of rôle-playing easy and rapid, not only for the children, but for the director. Teachers, for example, who followed our experiment with interest commented that they felt they could introduce rôle-playing into their classrooms more comfortably with the use of masks. Some of the teachers are planning to incorporate projects using masks and rôle-playing in their work.

Another advantage that we felt to be present in the use of masks was the 100-per-cent participation in rôle-playing on the part of the children. Whereas some of the children seemed to participate only with reservations in other parts of the program, they all engaged enthusiastically in rôle-playing with the use of masks.

During the course of the ten sessions with these children, we felt that we noticed a definite improvement in speech even during the periods when the children were not engaged in rôle-playing. To check our own impressions, we interviewed the teachers, one father, and three mothers of the children. We found that without exception each had noticed considerable improvement in his or her child's speech. By the end of the experiment, two of the children were judged by the experimenters, parents, and teachers as being completely free from blockage. On the other hand, we found that each of the children seemed to be "expressing" himself more freely in other ways in the classroom. Although there were no complaints from home, the teachers felt that the children were showing signs of developing "disciplinary problems" that they had not previously exhibited. Part of our program, then, incorporated some attempt to interpret to teachers and

to parents what these new behavioral expressions might be signifying in the lives of each of these children. We found the teachers interested, understanding, and coöperative.

Because of the exploratory nature of this study, we do not know just how important a place each of the various aspects of the group program described above holds in effecting the reduction of speech blockages and the increase of spontaneous behavior. An experiment is currently under way in which an attempt will be made to control as many variables as possible except that of the use of masks. We feel that the use of masks as an adjunct to rôle-playing is invaluable and that its significance in the development of new self-images may be considerable.

ABRAHAM Z. BARHASH

THE death, on December 24, of Dr. Abraham Z. Barhash has deprived the field of psychiatry of one of its most distinguished members. His loss is felt keenly by the large numbers of professional people who were privileged to work with him over the years.

Dr. Barhash was born in Russia in June, 1906, and came with his family to the United States at an early age. After graduation from New York University in 1927, he taught for three years in the Newark Public Schools. He then went abroad for his medical education and received his M.D. degree from the University of Vienna. In this stimulating atmosphere he became interested in psychiatry. He returned to the country of his adoption and furthered his medical training in the Beth Israel Hospital in Newark, where he made his home. He received postgraduate training in the Lenox Hill Hospital in New York, where he was the neurological resident. He received psychoanalytic training in Vienna.

His interests in child psychiatry, in which he has made such outstanding contributions, were nourished in the Louisville Mental Hygiene Clinic in Louisville, where he was a Commonwealth Fellow. From that period on, he has been a leader in all forward-looking developments in this specialized field of psychiatry. The opportunity for his unique talents for leadership on a national scope came when he assumed the directorship of the Division on Community Clinics of The National Committee of Mental Hygiene, later to become The National Association for Mental Health.

When Dr. Barhash took over this position, the American Association of Psychiatric Clinics for Children was just beginning to emerge as a standard-setting body. He had the opportunity to provide professional leadership to this organization and had the genius to make it an effective force in American psychiatry. He stood foursquare for sound training for the psychiatrists so needed to direct psychiatric clinics for children throughout the United States. He played a leading part in the creation of the American Academy of

Child Psychiatry—an important step in giving professional prestige to those psychiatrists who have earned, by their work, recognition as specialists in this field.

Among Dr. Barhash's rare gifts was his capacity to consult with communities that want and need to develop clinical facilities for emotionally disturbed children. He could catch the feeling of a community and evaluate its resources and its needs and sensitively guide them in sound planning for a community clinic. His help was sought throughout the country both while he was director of community clinics and after he had left that position to give more time to private practice. He never spared himself; he was in the best sense a social psychiatrist, with a genuine interest in people.

In his capacity as consulting psychiatrist to the new Ittleson Center for Child Research, a residential facility recently opened in New York City, he played a leading part in bringing this plan to fruition. In 1948 he was given the important position of secretary-general to the International Association of Child Psychiatry. In this position he became known throughout the world as one of our leading child psychiatrists and had a greater opportunity to use his organizing capacities. The plan for a clinical institute on emotional problems of the young child was his in a large measure, and the Toronto meeting this August will see this idea carried out. Even when his illness this past summer required him to reduce his active work, he remained actively available as a consultant right up to the end.

He was a devoted husband and father to two fine daughters. Those who had the privilege of being guests in his home saw the quality of this man in a family atmosphere that represented all one could desire in a family group.

He will be greatly missed, but he left a rich heritage of work well done.

FREDERICK H. ALLEN

BOOK REVIEWS

THE ART OF HUMAN RELATIONS. By Henry C. Lindgren. New York: Hermitage House, 1953. 286 p.

The anxieties and other disturbances treated in these pages are not the kind that require expert psychiatric service. The author, an associate professor in psychology in San Francisco State College, makes no pretense of offering guidance on such serious cases. His book can, nevertheless, be of much use. Handled wisely, it can help large numbers of people keep their minor ailments from becoming psychoses; and it can aid them along the road to that self-knowledge which is indispensable to emotional maturity. Moreover, the author's avoidance of technical jargon and his apt illustrations make the book especially useful for people of college age.

Unlike the writers of many a popular treatise on this head to-day, Dr. Lindgren wants his readers to be mindful of the difficulties involved no less than of the basic general principles. For instance, in the chapter, *Why Other People Are So Important To Us,* after sounding the warning not to demand that life be an unending series of successes, he points out how even the specialized techniques employed by businessmen to gauge the reactions of consumers may fail to bring the desired results, and how the individual, with "no corps of researchers measuring and probing the feelings and motivation of the groups he must work and live with, must rely on his own sensitivity and ability to interpret the words and actions of others. He can develop and improve this skill, yet it will never attain perfection. Thus we are often in the dark as to where we stand with respect to others. Often it is not until we have acted on the basis of what was our 'best guess' that we find out whether we were right or wrong."

> "The less emotionally mature we are, the more likely we are to drift into either extreme of conformity or rebellion. It takes a very mature person to yield gracefully, when necessary; to resist and stand up for his individual rights at the proper times; and above all to be both comfortable and productive in a group setting."

> "The hard fact of our existence is that, alone, we are nobody; we have to relate to others to be somebody. If our emotional growth proceeds normally, this fact will register with us. We may not consciously use it as a guide in our relations with other people, but if we are successful in achieving workable and satisfactory relations with the rest of the world, it will be because we have been able to accept this fact as a reality of our daily life. To ignore it or to fight it leads to difficulties."

The problem raises many questions about, among other things, the nature of the democratic process. Many of our civic failures go right back to these conflicts and our immature ways of meeting them.

> "Clever leaders are quick to suggest that even mild criticism of the existing leadership is really an attack on the group itself. Thus persons who try to bring about changes in the existing group arrangements will find themselves under attack both by the leaders and by large segments of the group itself. In fact, it is not even necessary for the leaders of the group to speak up in their own defense. Usually, any open criticism of the leadership or the current ways of doing things is sufficient to arouse anxieties in the group and instigate some sort of defensive action."

> "The founding fathers of the United States were aware of this tendency, and specified, therefore, that elections be held at stated intervals in order that the public might find it easier to make necessary changes in their political leadership. However, even with this proviso, the public's fear of change and its tendency to keep elected leaders in office beyond the span of their usefulness makes it difficult for those who wish to improve the efficiency of our government and bring its functions into greater accord with the people's needs."

The main theme is the therapy of daily life, especially how to treat the warpings inflicted on personality by forces hidden within the individual, by the influence of such important facts as the struggles for place and power in the business world, by the interplay of person with person, individual with group. On family life, for example, we read:

> "It sometimes takes all the emotional maturity we can muster to accept the fact that our growing children need less and less of our care and direction, or, rather, that they need care and direction of a different sort. It is hard to relinquish the pleasure of caring for a helpless babe, even when it is possible to enjoy a different kind of pleasure—that of helping a child to grow up. This second type of pleasure is more elusive than the first. Its enjoyment calls for more emotional maturity, because it demands that we share some of our power as parents, whereas everything within us which is immature and neurotic cries out against such a sharing of power. It is much easier to give a child an order and to have him carry it out without question than it is to discuss the situation with him and perhaps decide that the order wasn't necessary after all. The neurotic and immature elements which we inherited from our own childhood experience tell us that we must always be right, that we should expect complete compliance with our wishes. Yet realistically we know that we are not infallible. Furthermore, if we are particularly insightful, we will wonder whether we don't insist on obedience sometimes because we are bigger and stronger than our children rather than because we are right."

> "It is perhaps too much to expect that we can be a part of a grinding struggle for power in the world outside the home, only to drop all concern for power where the family is concerned."

> "The mature parent, the parent who is sensitive to his child's needs and who can communicate with his child, is more likely to be the parent who can apply or withhold direction and limitation as needed. It is the immature parent who is forever directing and limiting, who cannot let his child think for himself, or, at the other extreme, who exercises no control at all over his child."

All this is quite different from dwelling exclusively on Œdipus and Electra complexes.

For this broader view of psychology, the author acknowledges indebtedness chiefly to Horney, Fromm, Sullivan. He is modern in finding other reasons as well as sex for conflicts and immaturities—for example, the competition for prestige and power in a commercial economy, even though he is far from accepting the oversimplified view of Karl Marx. On sex he offers the much-needed view that what counts is the entire relationship, not merely the bodily gratifications, but companionship, tenderness, respect, home-making, parenthood, the fine art of being at the same time an individual and a responsible partner. Unlike mere passion, he says, love has to be learned; and "sexual incompatability" may be only a rationalization of other failures in the total union. Hence, of "all the situations which we normally encounter in our lives, the experiences of marriage and family living provide us with the richest opportunities to develop more mature patterns of behavior. Through these relationships we are enabled to meet our needs for love, security, companionship, self-expression and creativity. Meeting these needs requires the development of a wide number of skills in a variety of situations which family living most readily provides."

HENRY NEUMANN

Brooklyn Ethical Culture Society

READINGS IN MARRIAGE AND THE FAMILY. By Judson T. Landis and Mary G. Landis. New York: Prentice-Hall, 1952. 460 p.

This book of readings, by a leader in the field and his wife, is well organized. There is an introductory chapter on "The Contemporary American Family," which gives a much needed cultural context for understanding family relations in the United States to-day. Often one of the serious weaknesses of functional courses on preparation for marriage is the treatment of marriage problems as so many discrete and separate phenomena unrelated to the social situation. This weakness the Landises avoid.

They also use the valuable perspective, in subsequent chapters, of viewing family behavior in terms of stages of the family cycle. There are chapters on "Dating and Courtship," "How Mates are Sorted," "Predicting Marital Adjustment," "Weddings," "Husband-

Wife Interaction," "Family Interaction—Parents and Children," and "Aged Family Members." The remaining chapters have to do mainly with family problems such as bereavment, divorce, the rôles of women, and standards of sexual behavior. There is a concluding chapter on "Education, Counseling, and Research in Family Life."

The selections are also of a high order, contributed in most instances by leading authorities on various aspects of the family. Each selection is introduced by a brief head note.

The book ought, therefore, to serve students well.

M. F. NIMKOFF

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MARRIAGE. By Earl Lomon Koos. New York: Henry Holt and Company, 1953. 441 p.

SEXUAL HARMONY IN MARRIAGE. By Oliver M. Butterfield. New York: Emerson Books, 1953. 96 p.

There is an ever-increasing desire in men and women to-day to achieve successful marriages. This is illustrated by a growing demand for pertinent information in every area of marital adjustment. The capacities these young people have for functioning successfully in marriage is not enough. They must also know how to use these capacities, and must have a desire to use them. And they must learn which are the right values and goals for them.

These books represent the efforts of two disciplines, sociology and the ministry, to aid in the education of those about to marry, and to help them achieve a satisfactory and satisfying marriage.

The late Ernest Groves, a pioneer in the field of marriage and family living, left many excellent texts for use in such education. Koos has taken one of these books, *Marriage*, and not merely revised, but completely rewritten it to include the latest findings and theories in the field.

The book covers the subject of marriage thoroughly and exhaustively. The chapters on dating and courtship, which are of immediate concern to the majority of students, will certainly help them find their own answers by fostering independent inquiry, as is Koos's intention.

His approach to the subject is a well-integrated psychosocial one. The over-all picture of marriage in our culture, as well as the many marital difficulties that arise, are clearly illustrated by many pertinent case histories. A number of graphs, charts, diagrams, and cartoons further clarify the position of marriage to-day and the new directions it is taking.

Particularly noteworthy are the chapters on the sexual and reproductive aspects of marriage, which present the physical, emotional,

and cultural facets of this subject quite ably. The chapter, *Children and Marriage,* gives an excellent presentation of this area of marriage. Also *Rôles in Marriage* presents a fine analysis of the shifting rôles both of men and of women in marriage to-day.

The book is very well written. It presents the subject clearly and interestingly, and, because of its well-balanced approach, culturally, psychologically, economically, and medically, should be an excellent basic text on marriage for the student.

For those who have not had the advantage of college training, or the opportunity to take a course in marriage and family life, there are books on an aspect of marriage, the sexual, about which there is the greatest ignorance and misinformation. This is a vital area, and one fraught with much anxiety, and there is still, therefore, a need for books on the subject, such as *Sexual Harmony In Marriage,* by Oliver M. Butterfield.

In this book, a former minister gives what he feels are the salient facts young people should know about their sexual adjustment. It is well known that such adjustments are, of course, very individual. But it has also been found, by the success of such books as this, that there is a need for a general presentation on the subject. In his book, Butterfield discusses what a couple should know about the anatomy and physiology and some of the emotional aspects of sex and reproduction.

This small volume will be valuable both to those who give premarital instruction and guidance, and to those whom they advise.

LENA LEVINE

New York City

THE MENOPAUSE. By Lena Levine, M.D., and Beka Doherty. New York: Random House, 1952. 198 p.

This a helpful and enlightening discussion by a woman psychiatrist and marriage counselor.

The opening chapter of the book, *What is the Menopause?,* states at the outset that "women fear the menopause" just as their grandmothers did. They fear that it may bring insanity, loss of youth, and the classical symptoms of the menopause, the end of their sex life, and the loss of husband's love, of position, influence, and security. Dr. Levine feels that the menopause need not be feared, since it is as natural as menstruation.

She describes the physiological changes that accompany the menopause; then counteracts some misconceptions about it.

The second chapter, *What is a Woman?,* takes up changes in the attitude toward women during the past fifty years. Dr. Levine discusses some of the common difficulties of women in our society and speaks of sex as one of the worrisome aspects of the menopause.

The third chapter, *What Really Happens?*, describes different types of woman and how the menopause affects them. A number of cases are presented as examples.

The chapter, *What Can Be Done?*, suggests a physical examination to make sure that there is no other disease or illness, and then treatment for any physical complaints. The need for education in the actual facts of the menopause is stressed.

The last chapter, *What of the Future?*, emphasizes preparation for the later years. Dr. Levine states that there are places for older women in business, in industry, and in professional and volunteer work. Women will see that this bondage to their physical structure is no longer necessary, and as reasons for fear vanish, fear itself will fade away.

M. L. JAMES

The Marriage Council,
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PROBATION AND SOCIAL ADJUSTMENT. By Jay Rumney and Joseph P. Murphy. New Brunswick, N. J.: Rutgers University Press, 1952. 282 p.

It is a long, long time since the cobbler, John Augustus, appeared before the criminal courts in Boston to accept unofficial supervision of the men whom the judges committed to his charge. Probation has been utilized as a means of rehabilitation long enough for its practitioners to feel that there is a solid body of knowledge at the disposal of probation officers to enable them to carry out intelligently the direction of the court to aid its charges to a better understanding of themselves and of the world whose rules they must somehow keep.

The word *grace* in a theological sense means an unmerited gift. Probation is granted as an act of grace by the courts. No one has a right thereunto. The courts may be commanded by statute to imprison an offender for a prescribed period, and in some cases they may remit the service of the prison term, substituting a term of probation therefor. During that period, the offender is required to conform to certain minimal standards of conduct and to be governed by such special rules as the court may feel necessary. If he fails to meet these requirements, probation may be revoked and the offender imprisoned.

This system works well enough to enable the authors of the book under review to claim that probation in New Jersey has salvaged better than 60 per cent of the individuals under care.

Probation and Social Adjustment is a report of a research into what happened to the first 1,000 offenders placed on probation in

the year 1937. How many of these men, after ten years, were punished for further offenses? How many did well? How many died? How many disappeared from view? And so on. What standards of social adjustment were considered satisfactory for an individual placed on probation? Were these standards the same as those required of the ordinary run of citizens? Wherein did they differ? How did the probationers themselves regard the experience of supervision? Were they, in their own opinion, helped or hindered? Was it true that some offenders preferred to go to prison rather than submit to probationary supervision? These are some of the questions to which Mr. Rumney, a professor of sociology at Rutgers University, and Mr. Murphy, the chief probation officer of Essex County, undertake to find the answers.

The authors unite with Judge Hartshorne, of the federal bench, who writes the introduction to the book, to say that the purpose of the criminal law is primarily to protect society and secondarily to rehabilitate the offender. Rehabilitation, in its minimal sense, is accomplished if the offender does not reappear before the court, either for violation of probation or for the commission of a new offense.

As has been observed repeatedly, probation is, from the taxpayers' standpoint, an inexpensive way of rehabilitation. Depending on the type of penal institution, it costs from $600 to $2,000 a year to keep a man in prison. In 1948, the year of the research, the cost in New Jersey of probation administration was $62.25 per capita. Not even those with long experience in dealing with delinquency can estimate the human salvage when probation is able to prevent "disruption of family unity, the development of criminal careers, and the loss of human energy to our economic life, all of which occur when offenders are incarcerated; it helps to avoid the pauperization of families, and returns to taxpayers large sums of money collected in fines, restitution, family support, costs of courts, etc. These are positive values of probation which emerge largely unseen from the application of probation principles."

The book considers in order the sort of people who get into trouble with the law, and their social and economic backgrounds. It goes on to consider theories of social adjustment and the social adjustment of probationers. It discusses what can be considered improvement in the probationers' situations, and the types of person involved in relation to their offenses. It goes on to look at the chances of probationers' staying out of court and the techniques and procedures for preventing future crime. It reviews the techniques and procedures of probation administration and how these may be improved. And it has something to say as to how the probationer himself regards the process.

Those who deal daily with men living outside the law in one or more departments of life, and those who are too quick to accept popular stereotypes, would be well advised to ponder what the book has to say about criminals as people. It is too easy to set up a notion of the delinquent as living apart from the rules of society. The thoughtless are too apt to regard the criminal as one who lives with his hand raised against all and sundry, and expecting the worst of every one. This hasty generalization is founded on sand.

From the studies of Rumney and Murphy, it would seem that criminals—especially those on probation—are as much social conformists as the next person. That they have failed, for a variety of reasons, to live up to the standards society sets, is unfortunate. And our authors trace out a variety of causes for this failure. None the less, it is safe to say that the probationers studied more or less accepted the social norms of conduct, and on the whole made efforts—not always successful—to live up to standards that would at least keep them out of the courts.

The group studied did not appear to be a collection of vicious, antisocial enemies of society. This is not to say that some of them did not repeat criminal behavior and again appear before the courts. But one gained the impression that the causative factors were to be found in inadequacy rather than in the pursuit of a criminal career as an end in itself.

This does not in any way lessen the seriousness of the social necessity for protecting the community from the results of criminal behavior. But it does help to explain the situations of the men studied, and it contributes to our body of knowledge of the roots of crime and how to cope therewith. The book may be said to document by chapter and verse a position taken by us and by many others years ago[1] that the roots of crime are to be found as much as in any other place in the inadequacy of the criminal.

It would be a work of supererogation to commend the excellence of this book as an addition to the literature on probation. For this reviewer its chief value lies in its making available to the general student, as well as to the practitioner of probation administration and the experts, material that should be at the disposal of more than a small circle of men and women professionally involved in the social adjustment of those regarded as misfits or worse.

ALFRED A. GROSS

The George W. Henry Foundation,
New York City.

[1] See "Social Factors in Delinquency," by George W. Henry and Alfred A. Gross. MENTAL HYGIENE, Vol. 24, pp. 59–78, January, 1940.

CASE RECORD FROM A SONNETORIUM. By Merrill Moore, M.D. New York: Twayne Publishers, 1951. 50 p.

This psychiatrist has written more than 100,000 sonnets on human life and the world. The present examples show that, to quote from one of them:

> "Poets have rather unusual eyes
> That look at things in individual ways. . . .
> Their tools are simple. Poetry is hand-made,
> A rather crude art of words, and all they do
> Is make us look at things that they have seen
> With a peculiar clairvoyance of their own."

The book includes a series of cartoons by Edward Gorey on Moore's "liberation of the sonnet."

W. S. TAYLOR.

Smith College, Northampton, Massachusetts.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Vol. 7. Edited by Ruth S. Eissler, *et al.* New York: International Universities Press. 1952. 448 p.

How right was Freud when he said that in child analysis was the germ of future growth in knowledge and in psychoanalytic therapy. No better proof can be found than the successive numbers of this publication, with their pooling of theory and clinical observation by those who work with adults and those whose major contact is with children. The field of ego dynamism broadens with each annual review, and the interrelationship between the physical and the psychic is more closely knit. Technique as such is not openly discussed, yet the implications to change are there. Mahler's beautiful evaluation of contemporary knowledge of childhood schizophrenia not only is a clinical classification, but inherent in it are technical procedures that are applicable to adults. When will they be taken over by those who work with the psychoses, which are being handled more and more by the psychoanalytically oriented therapist?

The subdivisions of a symposium on ego development and the clinical papers are but an editorial convenience for the non-theoretical clinical contributions, which include a vast field of disciplines. In these the sociologist, the case-worker, and the educator each has his particular say. The essentially theoretical evaluation of ego phenomena, once headed by Reich, Nunberg, Federn, and now accelerated by Hartmann, Kris, and Loewenstein, are rounded out by contributions from Hoffer and Anna Freud, with trenchant discussions by Melanie Klein, Nacht, Scott, and Van Der Waals. The seminal nucleus is no longer ego and id as entities, but rather as symbiotic concepts which

have their bases in physiology, and thus have potentialities that are constitutionally inherent.

This is a significant acceptance, for heredity, which was once looked upon askance because of reasons emotionally determined by the investigator, is now faced as not necessarily fatalistic in concept. Actually, Freud has again been substantiated in that he always considered that physiology as a field would be explored by psychoanalytic investigators with increasing knowledge, and that therapy would be enhanced with scientific data regarding the physiology of man. Psychosomatic medicine is but a trend which substantiates that prediction. No one can point the finger of pedantry at dynamic therapy, for the investigation of ego defenses rather than so-called ego resistances is but the footpath that will open up broad vistas after the solid roads are laid. Contemporary developments have opened to others a new and fresh and exciting approach to more effective medicine.

The interest by Anna Freud in the somatic aspects has given rise to discussions on the rôle of body illness in the mental life of children. There are contributions by Bowlby, Robertson, and Rosenbluth upon the effect of hospitalization on a two-year-old, and Jessner, Blom, and Waldfogel have depicted the emotional implications of tonsillectomy and adenoidectomy. The impact of body illness and the reactions of the child to hospitalization are more thoroughly investigated, with observations on the psychic response before and after. Some years ago the reviewer discussed convalescence and its emotional repercussions upon the maturation of the individual. There is no more opportune time to evaluate psychic integration and resiliency than during the period of convalescence, but unfortunately at one time this was the concern and privilege only of the pediatrician. However, the changing and conjoint approach presents a more valuable therapeutic aid.

The first days of school—whether it be nursery, kindergarten, or even college—are major incidents, and they give us first-hand information regarding the individual's reaction to major change. The paper, *Separation Anxiety in Mother and Child*, by Else Pappenheim and Mary Sweeney, is significant in throwing light upon school problems. The social worker, under the guidance of the consulting psychiatrist, can here play a therapeutic rôle. How much the dynamics of adjustment problems can be evaluated at secondhand is a moot question, for so many nuances are lost in the telling. Seeing is assuring.

The spread of experience and the growth of knowledge inevitably lead to finer instruments for exploration, and there is no doubt that we are more often seeing neuroses and psychoses in a nascent state.

Meiss, in *The Œdipal Problem of a Fatherless Child,* Fraiberg in *A Critical Neurosis in a Two-and-a-Half-Year-Old Girl,* and Mahler in his outstanding paper, *On Child Psychosis and Schizophrenia: Autistic and Symbiotic Infantile Psychoses,* show what a change has taken place in the nature of child therapy in this respect. Children are seen earlier and therapy is instituted earlier.

The resultant flexibility in technique is high-lighted by Sylvester in her discussion of the techniques used to prepare young children for analysis. She gives the groundwork and the formation of a transference which must precede actual interpretation. Just as important is the education of parents, so that they will become coöperative allies instead of reluctant sceptics and potential disintegrators. Patience is a necessity, and the child psychiatrist often reflects upon how much simpler is the work with adults.

Christine Olden's notes on child rearing is an excursion into the history of education in the United States and a detour into the progressive-education movement, which has been more maligned than praised. The injustice lies in the fact that its critics have been belaboring the instrument when the fault lies rather with some of its practitioners. Permissiveness carried too far and aggression unsublimated were hardly in the philosophy of Dewey or Horace Mann.

Bere's article on aggression and Jackson's notes on flexibility are clinical contributions, Jackson's comments being particularly pertinent because the question of demand feeding comes under scrutiny. How flexible can a compulsive, obsessional mother be, and in what devious ways do the obsessional traits manifest themselves? How much can demand feeding be encouraged when it reaches inordinate lengths? After all, orality has its limits, too. The pediatricians are especially interested in this subject and eager to be guided.

Margaret L. Meiss's presentation of the Œdipal situation in a child who lost his father early in life sheds new light on circumstances that need exploration. The unweaving of this aspect of psychological growth is not halted here by an underlying neurosis as well as by the absence of a particular identification image. Confused as the picture is by the normal aspects of growth, as well as by unusual complications, one wonders how much therapy would be accelerated if the analyst were of the sex of the missing parental figure. In therapy, from time to time, this is a significant dilemma.

Lindemann and Dawes are engaged in a broad and extraordinary project, in which the dynamics of psychoanalysis are being used for community purposes; prevention, not diagnosis and therapy in themselves, is the goal. This project is unique in that it calls for a multi-

discipline approach in a broad sense. For the anthropologist particularly it is a rich opportunity, for here is not an alien culture, but our own.

Dr. Pearson brings to his subject, "Learning Difficulties," a background of great experience. Learning problems have been the object of much recent exploration through psychoanalysis by Hartmann, Kris, Gardner, Mowrer, and Rapaport among others. Many academic theories have been propounded—Hilgard mentions at least thirty. Although it has been primarily academic territory, little progress has been made, considering the effort invested.

In as much as motivation is a principal factor, the psychoanalyst has found it a fruitful field for investigation. While the progressive-education movement had its inception here (1928–29), Anna Freud and her students were experimenting in Vienna with psychoanalytically oriented education. The pedagogic journals that they published have much worth-while material in them.

Dr. Pearson has formulated, with much illustrative case material, a systematization of learning difficulties. He has differentiated the types encountered under those who can be taken care of by tutoring, a simple category; those that require tutoring and psychoanalytic therapy; and those that need psychoanalytic therapy before tutoring can be effective. Learning readiness is a much more comprehensive term than reading readiness and in actuality is the goal to be achieved. The process is really a replica of our therapeutic approach, for each therapeutic procedure, whether it be an orthodox psychoanalysis, psychotherapy, or academic pedagogy, is a dynamic phenomenon that takes in the individual (his past), the educator (parental or sibling image), and the material that is endowed with animistic qualities. Too little attention has been paid to the tutoring process, not alone the technical equipment, but the personality of the tutor, for the mechanics are secondary to the humanism of the educator.

Erich Lindemann succinctly summarizes the rôle of psychology in learning when he says: "The learning process, the ability to master and integrate complex situations without interference from unsolved emotional problems, and the distribution of libido between narcissism and object relations seemed to us to be a core problem of developmental psychology." Herein lies the nucleus of future therapy.

This publication has become a hardy perennial, with annuals that add color and luster to an abundant garden. Each spring brings anticipation and fulfillment.

EDWARD LISS

New York City.

THE LOVE AND FEAR OF FLYING. By Douglas D. Bond, M.D., with a Preface by General James H. Doolittle. New York: International Universities Press, 1952. 190 p.

Dr. Bond writes from extensive experience as a psychiatrist with military flyers and their problems. This book is based on that experience, but, as he remarks, "There will be some readers who will wonder what bearing this study may have upon civilian flying. . . . There is little doubt, however, that the same factors are at work" (in civilian and in military flying).

Dr. Bond's style is engagingly readable. The intelligent reader, from whatever background, will enjoy what he has written and will learn from it. The book, however, is written primarily for the psychologist and the psychiatrist. It uses their language and their concepts and it is too compact a work to contain explanations of its terms or even fully to document its author's conclusions. Like other such volumes, the reader should probably go through it more than once. Certainly all who do so will be well rewarded.

The chapter on the love of flying is not a full treatise on this subject, but in a surprisingly short space covers most of the points that have been considered by serious students of the topic. The chapter on recovery and treatment is particularly good, as is the last chapter, on diagnosis and administrative policy.

It is gratifying to find in a short work such real respect for the fact that we still have much to learn about predicting and treating failures in human adjustment and about furthering healthy adjustment in individuals.

This book is to be recommended to all to whom its title appeals. It should be owned and reread by all physicians who have to do with flyers.

OSCAR E. HUBBARD

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OUR COMMON NEUROSIS; NOTES ON A GROUP EXPERIMENT. By Charles B. Thompson and Alfreda P. Sill. New York: Exposition Press, 1952. 210 p.

This book embodies an effort to present in non-technical form some of the essential aspects of the altered orientation introduced in the field of behavior study by the late Trigant Burrow. It contains a selection of short articles and sketches originally published in *Mental Health* (1923–1926), a leaflet of the Mental Hygiene Society of Maryland, of which Dr. Thompson was at that time medical director. The essays were written by participants in Dr. Burrow's group-

analytic experiments and they reflect the trend of these behavior investigations as they were understood at this early period by some of the students.

Dr. Thompson and Mrs. Sill have arranged these sketches according to outstanding topics (group-analysis, emotional bias, social conditioning, the social neurosis, the "I"-persona, man as a unitary organism) and in their comments they evaluate the material from the point of view of the later phases of these group researches in which both were active participants.

A Foreword by Dr. Burrow briefly indicates the background and the specific circumstances that led to his experimentation in group- or phylo-analysis, resulting in "the first socio-biological clinic." In his early psychoanalytic papers (1911–1923) Dr. Burrow had already recorded his observations on the social implications of behavior disorder. In his view, focusing solely upon the neurotic individual did not permit a correct evaluation of disturbed behavior or meet the requirements of scientifically consistent procedure. He questioned the validity of the normal reaction-average as criterion of behavioral health and began to study systematically the unrecognized behavioral discrepancies of the social setting as they related to the more overt distortions of the neurotic patient.

This reorientation was not merely intuitive or theoretical. Rather, Dr. Burrow undertook to submit the dynamic network of social interreactions as they occurred in the actual group setting, composed of himself and his students, to intensive analysis and investigation. The aim was to recognize and examine disguised hostilities, socially corroborated narcissisms and self-deceptions, and other disruptive behavior expressions, as they presented themselves in the immediate group situation.

The investigation was not restricted to outstanding affect-inhibitions, idiosyncracies, and inconsistencies such as psychiatrist and social worker may single out in their attempts to trace neurotic reactions to parental influence. The endeavor was rather to determine the nature of a defect existing quite generally in the individual and his community interreactions, in the customary self and its social exchanges. The instances of a self-centered, autocratic mood, of an habitual tendency to affect-projection, of an obsessive preoccupation with the "rightness" of one's self-image were sensed, defined, and correlated. The attempt was made to relate these phenomena to a common denominator, to understand them as aspects of a dynamic socio-individual configuration of which an individual's neurotic disorder represents merely one of many possible expressions.

This brief comment on Dr. Burrow's early work is made in order to emphasize the altered frame of reference that *Our Common Neurosis*

presents to the reader. From this widened perspective, certain behavioral inadequacies both in the psychiatrist and in his patient are considered in relation to a common social problem, as expressions of an impairment in human relations from which no member of the community can exclude himself. Group-analysis involves a process of social self-inquiry and revaluation that must be a gradual development. The authors demonstrate one aspect of this development when, from the basis of a later stage of the social analysis, they comment on the evidences of self-centered bias, of sentimental or moralistic preconceptions that unwittingly entered into the writing of some of the essays presented in the book. In this way they attempt to bring to awareness the social neurosis in which they themselves admittedly are involved. The reader also is invited to sense his own share and responsibility in an adaptive disorder whose nature and socio-psychiatric implications are to be brought to clearer recognition.

As the authors point out, it is to be expected that this altered orientation, with its challenge to personal bias and socially systematized patterns of behavior, will meet resistance. The individual, whether "normal" or neurotic, inevitably defends his once established system of security devices. Irrespective of its morbid implications, the urge to self-justification is a powerful force and one of its expressions is self-defense against any inquiry into its own structure. We have here a vicious circle on the social level that presents a baffling problem and demands specifically adapted methods of observation and adjustment.

This social analysis of prejudice and emotional bias reminds one of the increasing reference in contemporary science to the rôle that unrecognized preconceptions play in many departments of investigation, especially those concerned with behavior and its disorders. It begins to be recognized more generally that an investigator's personal attitude or viewpoint, as individually and socially conditioned, determines to a considerable extent the choice of the questions he asks, the type of procedure he employs, the selection and interpretation of his findings. In recent reappraisals of the Freudian doctrines, for instance, reference is made to personal idiosyncrasies and culturally patterned prejudgements. While this growing recognition of the intricate involvement of the observer with the material that confronts him may assist in avoiding errors of perception and interpretation, the aim of group-analysis presented in *Our Common Neurosis* goes beyond this. It is directed toward a defect in the organization of the self that not only clouds our insight into human interrelations, but that bears a direct causal relation to the behavioral malfunctions toward which our medical and educational efforts are directed.

In the last two chapters of the book, the emphasis is on man as a

unitary organism. Evidence is cited of basic cohesion and integration in organismic and societal function as it has emerged in recent years from the work of biologists, psychologists, and anthropologists. It is pointed out that the essential importance of inherent coördinative forces, still inadequately appreciated in contemporary behavior studies, was very early emphasized by Burrow. In his principle of primary identification (1913) and in his later stress on phylic solidarity, he called attention to the rôle of dynamic integration in providing the necessary background for understanding and evaluating disintegrative developments. From this basis it becomes clearer in what way a divisive and destructive constellation may have come about in man with the advent of self-image, symbol, and language. The potentially disorganizing function of these human acquisitions is only lightly touched on in this book, and no attempt is made to consider more specifically the significance of these issues for the formulation of behavior disorder. Mention is made, however, of the differentiation of internally observable tensional patterns as they relate, on the one hand, to self-concerned affects and interchanges, and, on the other hand, to a more direct and socially coördinative attitude and interrelation. There are indications that work with these endorganismic patterns brings about far-reaching alterations of mood, motive, and action and thus opens up interesting possibilities of therapy and social reorientation.

In the investigation of personality and conflict, there has been quite generally increasing interest in the social aspect. Psychologists tend to view personality as a biosocial phenomenon; sociologists and anthropologists examine personality traits as products of class and culture; the various group therapies utilize the social setting in the readjustment of neurotic patients; the cultural school of psychopathology stresses the rôle of cultural and interpersonal pressures in the genesis of neurotic conflict. There is to-day considerable emphasis on social pathology, on society as the patient, on the morbid features of normality.

As mentioned, Trigant Burrow early laid much stress on these social factors, and in his group-analytic studies the negative or defective aspects of community behavior were submitted to direct observation. His challenge is a sweeping one and does not spare the observer's own feelings and perspectives. This may in part account for the scant reference to his investigations by workers in allied fields. But whatever may be the nature of the community's reluctance to participate in a careful study of its own motives and behavioral trends, the need for dissolving wasteful conflict and for a better coördination of human aims has not diminished. *Our Common Neurosis* offers a contribution toward the development of measures that meet this need.

The integration of insights and method necessary for this purpose parallels the search for unification of principles and procedures in other fields of science.

HANS SYZ

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HOPE FOR THE TROUBLED. By Lucy Freeman. New York: Crown Publishers, 1953. 250 p.

In her earlier book, *Fight against Fears,* Miss Freeman, gave an account of her own experiences in psychoanalysis. Here she presents what the jacket describes as "A Guide to the Various Aids Available for the Emotionally Disturbed."

Certainly the intent is to encourage those who feel themselves to be emotionally disturbed to recognize that emotional difficulties are treatable. The impression given by the book, however, is that only psychoanalysis is really helpful. Indeed, the statement is made (p. 205), "Psychoanalysis is difficult, expensive and takes a long time, but thus far, seems to be the only treatment that has helped." Indeed, so enthusiastic is Miss Freeman that she advocates lay analysis (p. 162), and even suggests that "as the influence of the American Medical Association [becomes] perhaps less," medical training may be bypassed for psychotherapists. On the other hand, and apparently inconsistently, we are told (p. 230), "The task of easing trouble belongs to sick man, poor man . . . . . parent, teacher, minister, lawyer, public health nurse, psychiatrist, and motorman-conductor. It belongs to all of us."

The book is written in rather jerky, almost telegraphic style, and contains numerous quotations. There is much information scattered throughout, including lists of state mental-health societies and national organizations in the field. The volume is essentially, however, testimonial and hortatory in character.

WINFRED OVERHOLSER

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PSYCHIATRY FOR NURSES. By Louis J. Karnosh, M.D., and Dorothy Mereness, R.N. Fourth edition. St. Louis: C. V. Mosby Company, 1953. 516 p.

The fourth edition of *Psychiatry for Nurses,* prepared by Louis J. Karnosh, M.D., with Dorothy Mereness as nurse collaborator, is considerably larger than previous editions. There are thirty-seven chapters and five hundred and sixteen pages in this edition. Some new material is included and the subject matter presented in former

editions is rearranged and expanded so that the present issue is even more useful than its predecessors.

The American Psychiatric Association recently revised its official nomenclature of mental diseases. The new terminology is employed in conjunction with classifications formerly used. This combination spans the period of transition and minimizes confusion.

The first three chapters are new in this volume. They present an introduction to psychiatric nursing designed to ease the tensions a young student nurse may feel at her first experience with patients who are primarily emotionally disturbed. Presumably she has had opportunity to observe patients suffering from ailments and has learned to recognize the significance of elevations in temperature and changes in pulse and respiration rates.

The patients she has dealt with in the general hospital usually ask for what they need and are concerned with their own safety. In the psychiatric service to which she comes, the seemingly physically well, ambulatory mental patient may puzzle the student and she may find difficulty in accepting the patient's need for hospitalization. Some psychotic patients present their conviction of being wrongfully detained in the hospital very convincingly, so that the inexperienced nurse requires assistance in perceiving the need.

The subject matter included in the text is well organized and prepared for the especial benefit of student nurses. Especially useful are the chapters devoted to the time-tested benefits of occupation, recreation, and hydrotherapy, as well as the more recently developed shock therapies and psychosurgery. Without preliminary explanation and supervision, the latter may be trying to the sensibilities of a young person seeing the procedures for the first time.

The increase of aging persons in our population is reflected in the growing number of elderly patients being admitted to mental hospitals, so the chapter devoted to care of the aged is timely. Nursing students will probably have many elderly patients to care for and an understanding of their needs will help greatly.

The problems of alcoholism and drug addiction are dealt with appropriately. Mental deficiency is described and its need for consideration in planning for community needs is implied.

Psychiatry for Nurses should retain its well-established position among the texts prepared for student nurses who are caring for mental patients. Some of the photographs that have been retained from former editions, however, could be replaced by more sightly presentations to the advantage of a useful volume.

MARY E. CORCORAN

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THE THERAPEUTIC COMMUNITY, A NEW TREATMENT METHOD IN PSYCHIATRY. By Maxwell Jones, M.D. and others. New York: Basic Books, Inc., 1953. 183 p.

It has been obvious for some time that many character disorders that present behavioral difficulties not amounting to psychoses have been almost impervious to treatment by direct or indirect psychotherapy. For this reason group methods and social programs of various types have been developed. The British Government, in its rehabilitation program, has encountered many individuals who are unemployable by virtue of personality defects, and has sought to evolve methods to treat this therapeutically immovable group.

In this area Dr. Maxwell Jones and his associates have developed methods of environmental treatment at the Industrial Neurosis Unit in the Belmont Hospital in England. The patients they treated were sent them from many parts of Britain by the disablement resettlement officer, under the ministry of labor. This book is a modest and straightforward account of the technical problems involved in treating these persons, over a period of three or four months each, in a "therapeutic community."

The methods employed are not spectacular, but they are aimed at changing the traditional nurse-doctor and nurse-patient relationship, with the addition of occupational therapy on a realistic level. That is, the patients worked at industry just as they would in the outside world without being subject to any patronizing attitude or coddling. There was one significant difference however: every reaction of the patient to his fellow worker (patient), nurse and doctor, and the hospital community was studied in detail in group sessions, staff sessions, and individually. The results of this revision of relationships in the hospital point—in the words of Goodwin Watson, who wrote the Foreword to the book—to a "great step forward which may have consequences even more far-reaching than those flowing from psychoanalytic discoveries." The essence of the therapeutic viewpoint has been to examine "normal interactions in community life" rather than the specific pathology in each individual.

The cases that Dr. Jones and his group worked on were those classed as "hopeless" or "failures in society." The treatment was that of constructing a new therapeutic environment, with many interesting features. For example, the nurses functioned actually as social workers, not unlike those psychoanalytically trained social workers who are used more and more in hospitals in this country.

The psychologic position of the nurse in relation to the patients was analyzed in frequent staff meetings along with that between nurse and doctor. The authoritarian relation of doctor to nurse, which has been deeply ingrained in medical tradition, was discarded: the white

coat and "aggressive percussion hammer" traditional for the hospital physician were done away with.

The therapeutic community was allowed to be more natural and psychologically intimate than many hospitals have dared to allow it to be up to now, more like a family than an institution in the formal sense. The whole period of the patient's residence in the hospital was thought of as therapeutic. Interpretations were made by the psychiatrist of various occurrences of community life—aggressive outbursts, developing love relationships, soldiering on the job, and so on—to the end that the total process of acculturation going on during the treatment process might be analyzed with individual and group patients.

The total results of work in this group seemed to be good. It is the belief of this group of workers that the results achieved could not have been accomplished on a basis of individual psychotherapy or hospitalization alone (p. 156). They stress the very vital point that the capacity of the individual for change, rather than the severity of his illness, is the important factor in estimating prognosis. They feel that the factors of "employability," and hence changeability, are much more important in the individual patient than specific psychopathology as measured by projective tests, and so on. In other words the ego-adaptative forces is the factor these authors stress, rather than ego inhibitions in whatever form they take, in the internal dynamic economy of the patient. This is, at least, the reviewer's summary of the authors' final chapter, "General Conclusions."

The book is an interesting, though rather generalized, report of this study in the field of social therapy—a field that is becoming more and more important as psychotherapy broadens to move out of the consulting room into areas of pathologic social interactionism. The book is recommended for study by every one interested in the potentialities of the psychopathic personalities and maladjusted persons who present themselves for care and help.

WALTER BROMBERG

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WOMEN IN THE MODERN WORLD—THEIR EDUCATION AND THEIR DILEMMAS. By Mirra Komarovsky. Boston: Little, Brown and Company, 1953. 319 p.

Within the compass of some three hundred pages, the author of *Women in the Modern World* repeatedly poses the question, "What are we educating women for?" After considering the various issues —sociological and psychological—that have a bearing on the problem, Dr. Komarovsky concludes that to answer this question, "we would have to face the whole problem of women's rôle in society," and that "we are uncertain about the ends of women's education precisely

because the status of women in our society is fraught with contradictions and confusion."

She then proceeds to trace the "life cycle of the middle class, and especially the college trained, woman from adolescence to middle age, in order to lay bare the inconsistent social expectations and other social forces which cause conflict at every stage of her life."

Under such headings as *Do Psychological Tests Support the Case for a Feminine Curriculum? Psychoanalysis and Women, Learning the Feminine Rôle, The Homemaker and Her Problems, Home Plus a Job, Ethics and the Sexes,* etc., she attempts to "locate the obstacles barring women's pursuit of the good life and to clarify the uncertain ends of women's education." She flashes the beams of sociological, psychological, and psychoanalytic searchlights upon her topic from various angles, and the strongest of these is the sociological.

The final chapters, six and seven, cover a gamut of considerations under the general headings of *Can College Educate for Marriage and Parenthood?* and *Towards a Philosophy of Women's Education.* In these two chapters Dr. Komanovsky touches upon the social roots of personal conflicts, student counseling, understanding one's self, family relationships, parenthood, needed educational reforms, spanning the gap between classroom and reality, vocational preparation, and so forth.

At no point is there a clear statement of what is the author's definition of education. One might be misled at the beginning to believe that it is preparation for family life where women are concerned, and that distinctive feminine curricula are the solution. In the last chapters, however, Dr. Komarovsky asserts the humanity of women and their equality and states that "important as it is that college opinion be favorable to family life, it must also endorse the fullest development of the intellectual, artistic, and professional aspirations of women" and "provide a soil for the fullest fruition of intellectual gifts." She then advocates "the need for a rich and flexible curriculum within which both the common and the unique talents of individuals, irrespective of sex, will be recognized and fostered."

The author blames society for making "a formidable educational effort to develop the potentialities of women, at the same time allowing certain outmoded traditions partially to defeat this purpose." She ends by saying that colleges alone cannot accomplish the task of resolving women's dilemmas, but that they could be alleviated by certain changes in public opinion and women's own understanding of and attitudes toward their status in the modern world.

Perhaps because of her attempt to touch upon so many of the contradictions of our era where women are concerned, and the many topics she brings into the picture, the book does not bring out clearly

Dr. Komarovsky's conclusions on "what kind of education can best serve the unpredictable future," which she claims to be the subject of the book as a whole.

If the book is written mainly for college women and educators, too much space is devoted to the discussion of "the dilemmas" and too few pages to possible solutions. For people who have not had courses in sociology and psychology, it is an intersting, readable reference volume, written in informal style. Points are well made through the use of illustrative cases—a procession of women in various adjustive processes. The manner of presenting them fosters constructively argumentative thinking. The bibliography is carefully selected and well grouped under chapter headings.

There is no capsule answer to the question Dr. Komarovsky poses for herself—"What are we educating women for?" And as a result she has attempted in one volume to go into subjects that are often the objectives of several texts or college courses. In spite of that, the book has many features to recommend it, especially its rather searching social analysis.

ESTHER M. DIMCHEVSKY

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RETIREMENT AND THE INDUSTRIAL WORKER. By Jacob Tuckman and Irving Lorge. New York: Bureau of Publications, Teachers College, Columbia University, 1953. 102 p.

This book presents many facts and tables relating to the attitude toward retirement of members of the New York Cloak Joint Board of the International Ladies' Garment Workers Union. In view of the very high rate of compulsory retirement in American industry, this study of what people who are to be retired think is important. It is important not only to those interested in sociological problems, but also to those who plan retirement programs and to those who finance them.

The following quotations give some idea of what the reader will find in the book: "Just about half the respondents either look forward to retirement or like retirement. Yet even this attitude is negatively oriented: they want to retire because they feel that they are no longer able to work because of declining health or old age, or because they 'desire to rest' or feel that they have 'worked long enough.' Few of these seek or sought retirement to have a good time or to carry out plans long postponed." ". . . only half the applicants have done anything to prepare for retirement." "The activities planned for retirement . . . indicate that apart from 'taking it easy' few of the respondents have given any thought to . . . how they will spend their retirement time."

Other statements with regard to the great number of retired persons who feel that they would like to live in groups with other retired individuals, as well as the fact that many wives do not look forward with pleasure to the retirement of their husbands, are thought-provoking.

The first sentence of the authors' conclusions expresses the feeling of the entire book: "This study indicates that industrial workers approaching retirement age have a deep resistance toward retirement."

GEORGE H. PRESTON

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A MANUAL OF FIRST AID FOR MENTAL HEALTH IN CHILDHOOD AND ADOLESCENCE. By Sidney L. Green, M.D., and Alan B. Rothenberg. New York: The Julian Press, 1953. 279 p.

Among the many books on psychiatry written for the layman in recent years, this one has an entirely different approach. Like the American Red Cross' *First Aid Textbook*, with which the authors compare it, the volume deals with emergencies and describes what the bystander should do until, in this case, "the psychiatrist arrives." Included in the various chapters are problems that could arise in any family, such as the death of a close relative; hospitalization; witnessing or being a victim of an accident; the birth of a sibling; fear of animals, lightning, darkness, and so on. The discussion of these situations makes the book useful to parents and to workers, such as teachers, clergymen, Scout leaders, and camp counselors who come in contact with children.

Other sections dealing with forms of delinquency, such as vandalism, truancy, and drug addition, offer valuable information to citizens in general who are concerned with the rising tide of serious maladjustment in our adolescent population. There are also chapters on emergencies arising from suicide attempts, sex attacks, and cruel and unusual punishments, which fortunately are not common cases. It is doubtful if those confronted by these problems would have opportunity to consult the book either before or after the crisis.

The authors are both active in the field of preventive psychiatry. Dr. Sidney L. Green, a practicing psychoanalyst, is Chief of the Psychiatric Staff of the Community Service Society of New York, in addition to having many other psychiatric affiliations. Alan Rothenberg is a member of the Board of Directors of the Brooklyn Association for Mental Health, and is also a teacher in one of the New York City public high schools.

Their philosophy is a wholesome one, stressing the child's feeling of dependence and his need for a calm, confident, warm-hearted

person to whom he can turn in major and minor crises. Dr. Green and Mr. Rothenberg would like to develop, as the Red Cross has done for physical emergencies, a vast corps of mental-health first-aiders recruited from among the ranks of parents, teachers, clergymen, camp counselors, and so on, who would know what immediate help to offer in times of emotional trouble and how to prevent further psychological damage to the injured person.

Accordingly, in the manual each situation is described in terms of behavior patterns, so that the first-aider can recognize the problem with which he has to deal and can understand what it means to the child concerned. Then the goals of first aid in the specific case are enumerated. The objective is always the lessening of fear, through giving the child assurance that he is loved and respected and will be taken care of no matter what has happened to him or what he has done.

The admonitions given under the subtitle "Don'ts" are very important because unwise treatment—such as forcing a child back into a fear-producing situation—may make the emotional effects of an accident lasting instead of temporary.

"Do's" for each situation are listed in as practical and definite a manner as possible. However, the authors frankly state that they cannot provide the easy array of "what to say" phrases that parents and teachers constantly seek. They explain that the reason why a formula for each occasion would be useless is that children do not respond to words. Children express themselves actively, not verbally. Correspondingly, it is what the first-aider does, not what he says, that is important to a stricken child.

Each section also contains a clear statement as to the circumstances under which psychiatric or guidance help is indicated, and one of the final chapters supplies directions for getting in touch with appropriate professional persons or agencies.

Because of its practical approach and its challenging workshop examples, the book serves as a good introduction to the study of mental health. For parents and others who are working with children and who are, therefore, constantly beset with emergencies, it gives a *modus oparandi* even for situations not specifically covered in the text.

If the next generation is to grow up with better mental health than the present one, more adults must develop an understanding of juvenile problems as they look to the child, and must be aware of the need for true adulthood in themselves. The qualities of warmth and self-control that make a good first-aider are also those that make a good parent or teacher.

RUTH ANNE KOREY

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NOTES AND COMMENTS

Annual Meeting of the American Orthopsychiatric Association

The American Orthopsychiatric Association held its Thirty-first Annual Meeting at the Hotel Commodore, New York City, on March 11–13, 1954. This was the first meeting of the association in New York City since 1948. It was attended by some 3,700 members and guests.

Approximately 90 scientific papers were presented by psychiatrists, psychologists, social workers, educators, sociologists, and anthropologists. One section held an all-day session on the subject of residential-treatment centers for emotionally disturbed children. There were eighteen case workshops, one-and-a-half days of selected mental-health film showings, demonstrations of psychodrama, and numerous technical and commercial exhibits.

The presidential session was concerned with "Causes of Family Breakdown." The papers, symposia, and round tables that followed were on various orthopsychiatric themes, including psychotherapy, child development, psychosomatic disturbances and their treatment, mental health in the schools, and other related subjects.

The officers elected for the coming year are: Dr. Simon N. Tulchin, of New York City, president; Elizabeth Holmes, of Boston, vice president; Dr. Exie E. Welsch, of New York City, president-elect; Dr. William Langford, of New York City, treasurer; and Jessie E. Crampton, of Brooklyn, secretary.

The 1955 meeting of the association will be held at the Hotel Sherman, Chicago, February 28 to March 2.

Annual Meeting of the American Group Psychotherapy Association

The American Group Therapy Association held its Eleventh Annual Conference at the Henry Hudson Hotel, New York City, on January 15 and 16. Among the subjects discussed were "Selection of Patients for Group Psychotherapy," "The Analysis of a Tape Recording of a Group Psychotherapy Session," "Transference and Counter-transference in Group Psychotherapy," and group psychotherapy in various settings—in mental hospitals, in general hospitals, in private practice, in the treatment of addiction and alcoholism, in child guidance, and in related fields. The program included also workshops and general sessions, a cocktail party, and a luncheon.

Rôle of State Mental-Hygiene Societies Stressed at Governors' Meeting

The Indiana citizens' mental-health movement, as represented by the non-governmental Indiana Association for Mental Health, was cited to the governors of the forty-eight states as the outstanding example of how to protect the interests of state-hospital patients. The acclaim came from the man who, as governor of Minnesota until he resigned to join the federal judiciary, is regarded as the father of the current nation-wide wave of activity by state governments in mental-care reform. He is Judge Luther W. Youngdahl, of Washington, D. C., a principal speaker at the Governors' Conference on Mental Health, recently held in Detroit.

Youngdahl, at an overflow meeting, told the governors: "I certainly congratulate Governor Craig, of Indiana, for being the chief executive of a state whose citizens' mental-health association emerged from the first nation-wide mental-health drive as the strongest in the country."

Basing his remarks on his own nationally acclaimed experience in Minnesota, Youngdahl stated: "Administrators need to understand the rôle that an independent citizens' group can play to insure the continuity of mental-health programs and to protect them against political attacks."

"The governorship," Youngdahl pointed out, "is not like a residency in a state hospital in the old days, when a patient, just as often as not, stayed for life. With few exceptions, none of us stay in office very long. And no legislative body to my knowledge can pass on a liability to its successor or guarantee that the next session will not repeal what the preceding one initiated.

"I don't have to tell you that the body of experience that one administration acquires often is lost in the line of succession or in the political changes in a state.

"For that reason it is important that we consider several factors. First, we must let the public know what progress we are making to improve conditions. But at the same time, we must acquaint them with the many unmet needs that no one administration can fully meet. This means on 'open door' policy to the press, to the responsible citizen agencies in this field, and to the public.

"Equally important is the fact that we recognize in our mental-health departments the experiences of the health departments in coöperating with the voluntary agencies in such fields as cancer, heart, polio, orthopedics, and the physically handicapped of all types.

"Such coöperation is needed in the mental-health field, if our programs are to achieve the degree of maturity and support that have been reached in the more deeply entrenched health fields.

"Even more important is it that we must recognize the rôle that a good state mental-health association, made up of citizens and completely independent of the state government, can play—as a non-self-pleader—in voicing the needs of the patients . . . and in supplying continuity in public opinion over a period of time greater than our own individual span of office.

"To the extent that what we are able to do—and to leave behind us—reflects the apathy or the support of the public, the recent development of strong state mental-health associations is the greatest asset our programs can have.

"I am pleased to see that in the last year or two more and more citizen groups have been formed and strengthened."

President of the National Association for Mental Health Congratulates Governor Dewey

The following letter was sent by Mr. Richard Weil, Jr., President of The National Association for Mental Health, to Governor Dewey, congratulating him on the mental-health program that he has proposed to the state legislature:

"Dear Governor Dewey:

"In behalf of The National Association for Mental Health, may I offer my congratulations to you on the mental-health program which you proposed to the Legislature of the State of New York Wednesday, January 6. Your proposed program demonstrates once more the leadership which the state of New York has taken in recognizing the seriousness and extent of mental illness and in acting to combat it.

"It is heartening to note that a state which already ranks at the very top in the provisions it is making to give adequate treatment to the mentally sick and to prevent mental illness through community mental-health services recognizes that even these superb efforts are not yet adequately meeting the problem and that additional efforts must be made. We are gratified additionally by the fact that your program does not select just one aspect of the problem, but rather covers all important aspects—including prevention, treatment, humane care, and rehabilitation.

"The National Association for Mental Health and, in New York State, its affiliate, the New York State Society for Mental Health, have long urged that the only assault on mental illness that can make any real headway is a comprehensive one, for if we prevent mental illness and do not provide for the hundreds of thousands already stricken, we have abandoned helpless children, men, and women; and if we provide treatment, but do not take steps for prevention, then we only perpetuate the problem; and if we provide treatment without rehabilitation, then we are again condemning those who have recovered to lives of unhappiness and rejection in their own communities, and in many cases to a return to the mental hospital.

"Another aspect of your proposed program which elicits our gratitude and admiration is that which proposes the establishment of a permanent

local mental-health service with state aid, similar to the program to establish and to aid local health boards and departments. There have been hundreds of instances throughout the country where sincere efforts to improve prevention and treatment of mental illness have been short-lived because of the failure to make adequate long-range administrative provisions to implement these proposed improvements.

"In taking the long-range view, your proposed plan will eliminate many of the pitfalls which are encountered in piecemeal, stop-gap programs.

"We are confident such a program will have the heartfelt support of the people of New York State, because the people are at last beginning to realize that mental illness is not 'the other man's problem,' but their very own, affecting, as you have stated, one family in every four directly, and *every* family, without exception, directly or indirectly.

"Again our thanks and congratulations.

"Very truly yours,

"RICHARD WEIL, JR."

Dealing With the Problem of Alcoholism in New York City

Medical, psychiatric, and social-service facilities for the treatment of alcoholics in New York City are "grossly inadequate," according to the 1953 report of the Committee on Alcoholism of the Welfare and Health Council of New York City, recently made public by Harold Riegelman, chairman of the committee. Although progress was made during the year, the report states, it was "small in comparison with the great need to control the disease of alcoholism and provide better facilities for the rehabilitaton of its victims."

Calling attention to the fact that "alcoholism is an active factor in the lives of 200,000 residents in this city," the report points out that this "accounts for losses in wages, medical costs, and lost production amounting to more than $200,000,000 a year." These losses, the report adds, do not include the cost to the city of dealing with alcoholics who are convicted of offenses associated with alcoholism or alcoholics on relief or cared for by the department of welfare.

The report notes six areas that call for further exploration by the Welfare and Health Council. These are:

1. The development of more precise and generally accepted terminology in relation to the disease of alcoholism; and an acceptable system of medical reporting of cases treated by physicians. Until progress is made along these lines, statistical data concerning the illness and the effectiveness of various kinds of treatment will continue to be unreliable.
2. Encouragement of hospital-connected medical schools to establish inpatient and outpatient clinics with or without state aid, and the reëstablishment of an alcoholic ward at Bellevue Hospital.

3. The development of more effective instruction in public, private, and parochial schools for the prevention of alcoholism.
4. Encouragement of the newly elected city administration to accept responsibility for supporting remedial measures in the welfare department, the magistrates' courts, and the department of hospitals.
5. The establishment of commitment procedures of a civil or quasi-civil nature along the lines recently enacted in other states.
6. Inducement of the several health-insurance plans to accept alcoholism as an insurable risk.

The report describes the aid given by the state in creating new clinical facilities in other cities; and state assistance in New York City in the establishment of the clinic for alcoholics at Kings County Hospital in Brooklyn and the experimental clinic in Home Term Court at 300 Mulberry Street in Manhattan. These are a good beginning, the report comments, "but it is noted with deep concern that except for the specialized Home Term Clinic, there are no low-cost inpatient or outpatient clinics in Manhattan or the Bronx where the need is most pressing. Hospital-connected medical schools seem strangely unaware of, or financially unable to meet, their responsibilities in this critically important and neglected area of public health." These schools have not yet responded to the state's offer of financial assistance, which continues to be available.

Praising the project for homeless men on Hart Island, maintained by the city's department of welfare, the report explains that the rehabilitation process for the large percentage who are alcoholics includes medical treatment, occupational training and therapy, Alcoholics Anonymous, and church coöperation, in a program averaging 10 weeks. The Hart Island project was opened in 1950, the report recalls, and its effectiveness "is proved by the fact that about half of its 'graduates' have not reapplied for further help from any of the department's Shelters." Approximately 2,000 homeless men were admitted in 1953.

Experience at Hart Island, the report states, has shown that more men could be salvaged if they were returned to self-maintenance under some guidance at a "halfway house." Immediate action is urged, therefore, on the committee's previous recommendation for the establishment of such a transitional facility.

The report recommends, also, that Hart Island services be made available to department-of-welfare clients who have an alcoholism problem, but are not homeless; that the facility be opened to persons with alcoholism problems who come through the domestic-relations court as well as the magistrates' courts; and that continued efforts be made

to obtain legislation for civil commitment and voluntary admission of alcoholics to non-penal treatment facilities.

"Encouraging developments" on the penal aspects of the problem are listed in the report: the creation of the homeless-men's court; the integration of the Hart Island program into the judicial framework; and the reorientation of the department of correction's provision for rehabilitation of alcoholics on Rikers Island on the model of the Hart Island program. The report notes, however, that "progress made at Rikers Island in providing facilities for the rehabilitation of alcoholics is handicapped by the absence of psychiatrists and psychologists." The report adds also that the general need for adequate screening facilities at Rikers Island has not yet been met.

The report also makes reference to the meetings of Alcoholics Anonymous in a courtroom at 100 Centre Street, and in connection with this and other rehabilitation measures, it comments: "It is hoped in this way to emphasize a new judicial approach to the problem of alcoholism. Where previously the courtroom was used to punish the alcoholic, it will at least in this connection be used to aid and assist him."

Marked Rise in People Seeking Help From Family-Service Agencies

Troubled people, seeking help with personal and family problems, are coming to family-service agencies across the country in markedly increased numbers, according to a recent statement by Clark W. Blackburn, General Director of the Family Service Association of America.

Reports of a representative group of 57 member agencies in various cities indicated an average increase of 5 per cent in the number of persons accepted for service in 1953 as against the previous year, and an average rise of 2 per cent in the number of cases served per month. During the last quarter of 1953, however, the monthly "intake" was 8.6 per cent greater than in the same quarter of the previous year and the number of active cases rose 6 per cent.

Individual agencies experienced considerable variation in the demands for services made upon them during the year, including the last quarter, when the greatest upswing was noted. In a number of communities, including many large industrial cities, the number of applicants accepted showed a phenomenal rise over the last three months of 1952. In Los Angeles, for example, one agency experienced a 67 per cent increase in "intake" during the last quarter; a Chicago agency, 29 per cent; one in Akron, 42 per cent; Worcester, Mass., 63 per cent; and one in New Orleans, 28 per cent.

The upswing is attributed partly to the fact that family-service agencies are becoming better known and accepted as places where professional, confidential help with personal difficulties is obtainable. Miss Esther M. Taylor, General Secretary of the Family Service Organization of Louisville, Ky., for example, said, "The most important factor, I believe, is the widespread interpretation of the family-service agencies as having something to offer families who are troubled in their family relations. Our increase primarily has been from husbands and wives coming in for help with their relationship problems."

Likewise, in Utica, New York, Miss Ruth Zurfluh, Executive Secretary of the Family Service Association, said increased applications were primarily due to "the type of service offered by the agency with problems of personal adjustment and the community's growing awareness of the existence of the agency through a variety of media over the past five years." She added: "Nationally, we are seeing a growing awareness that problems of interpersonal relationship are not only universal and normal to the attempts of human beings to get along with each other, but that getting help is a constructive way of handling the things one can't do alone."

A second factor in the added pressures for agency services in many cities, however, was the change in the economic climate during the last half of the year, due to an increase in unemployment, lower family income because of less overtime, and fears about possible job loss. Although generally financial assistance for families in economic need is a public responsibility provided through public-welfare departments, many families are seeking the help of the voluntary family-service agencies in income management and in family readjustments growing out of their job worries.

In Springfield, Mass., Mr. Robert W. Poole, Executive Secretary of Child and Family Service, reported that "many additional requests have come in as a result of the necessity for families to readjust following either reduction in work or a lay-off and the securing of a less adequate job. An instance is the veteran with three children who bought a house on $90 a month G. I. payments when he was earning $110 a week. Now that he is cut back to $60 a week, he is in real trouble."

In Houston, Texas, Mr. Walter W. Whitson, Director of the Family Service Bureau, attributed increased demand to a "satisfied clientele over a period of years, to increased attention to family counseling in national magazines, and establishment of a fee schedule for those who can pay for counseling service." But, he added, "For the last few months our intake and brief services have increased because of a

general increase in unemployment in the city. Although most requests for financial aid must be referred to public welfare services, there is a relationship between the economic situation and family relationships with which we are able to assist."

Mrs. Blythe W. Francis, Executive Secretary of Family Service of Los Angeles Area, said that a breakdown of the 67 per cent gain in intake in that agency for the last quarter of 1953, indicated a 44 per cent increase in marital problems, a 38 per cent gain in parent-child difficulties, and a 106 per cent upswing in economic problems in the cases served by the agency. "The changing economic scene has brought many lay-offs and shorter working hours," she said, adding that "financial pressures frequently precipitate marital and other family relationship problems." Part of the agency's increase, however, was due to reorganization of the agency's district staffs, making possible more coverage of applications and greater ability to serve more persons. At the same time, "staff resources are not sufficient to give continuing service to many clients who need and desire it."

In Chicago, Miss Jeanette Hanford, Director of the Family Service Bureau of United Charities, attributed the rise in people served "to an increased program of interpretation, a greater readiness on the part of the public to use professional help with personal problems, less staff vacancies in recent months, and reorganization of our application service so as to permit a closer and more careful working arrangement with the Chicago Community Referral Service." Miss Hanford added, "We are beginning to see an increase in applications related to the change in the economic situation and our intake partly reflects applications for assistance, which are referred to the public-welfare department."

Despite frequent mention of weak spots in the employment situation, the 57 agencies showed a 20 per cent drop in the giving of financial assistance, most of which is provided by the voluntary agencies only on the basis of emergency or to supplement in a small way the plans for helping a family. The fact that the monthly client load of the agencies was throughout the year only 2.1 per cent higher than in 1952, while "intake" was 5 per cent higher, indicates that the agencies generally are helping more people over shorter periods of time. This was further suggested by the fact that while case loads of individual workers remained at about the same level as in 1952, the number of in-person interviews per worker was higher than in the previous year.

On the basis of the averages among the reporting agencies, the national association estimates that in 1953 its 255 voluntary agency affiliates served close to a quarter of a million families, comprising 825,000 persons.

Veterans Administration Expanding Its Program of Paid Hospital Work for Long-Term Mental Patients

The Veterans Administration has announced that its plan for the final rehabilitation and discharge of long-term mental patients through a program of paid hospital work has been so successful in the pilot study that it is being expanded for general use. The V. A. said that the pilot program not only has resulted in the release of many long-term patients who were thought to have little chance of returning to the outside world, but, equally important, it has brought about their discharge after they had been equipped and conditioned to compete successfully under normal conditions.

Long-term patients, although medically rehabilitated, are often fearful of leaving the hospital because they have lost job skills and experience during their extended stay in the hospital. In order to bridge the gap, these patients are transferred to member-employee status, so they may take necessary, unfilled hospital jobs at set wages and regular hours while they continue to live in the controlled environment of the hospital, with medical care, board, room, and recreation furnished them.

In this way, member-employees may develop a work pattern or learn to work again under the understanding supervision of the hospital and, in addition, take care of themselves as to their everyday needs, mix with regular employees on an equal basis, handle successfully a weekly salary, and carry themselves confidently on visits outside the hospital.

With the success of the pilot program already an established fact, the V. A. has notified its 38 neuropsychiatric hospitals all over the nation that they now may institute the new rehabilitation program if they have the facilities to quarter patients as member-employees.

The pilot program at the V. A. hospital in Perry Point, Maryland, still is under way. It was instituted by Dr. Peter A. Peffer while he was manager of the hospital. He now is manager of the new neuropsychiatric hospital in Brockton, Massachusetts, where he plans to expand his pioneering endeavor in the new rehabilitation technique.

At Perry Point, approximately 70 men who had been hospitalized for an average of ten years each, were given the opportunity to become member-employees. Some who previously had been considered as having little chance of returning to the outside world now have regular jobs away from the hospital and are making a good adjustment as self-supporting citizens.

In placing these men in jobs outside the hospital, Perry Point found it was not difficult to convince employers that the men were capable

of sustained work. The careful work records maintained by the hospital, based on a regular eight-hour, five-day-week performance, were sufficient proof that the men were ready and able for outside employment.

Since member-employees are placed in unfilled, but necessary, hospital jobs, no increase in the personnel ceilings of the participating hospitals is needed, the V. A. said. That means, that the program may be conducted at no additional cost to the government, but with the potential savings that result from the more speedy return of mental patients to the outside world.

The V. A. considers the new rehabilitation plan as an invaluable addition to its program for hastening the recovery and the ultimate economic adjustment of its mental patients. The new plan is valuable also because it is likely to achieve the successful release of long-term patients where other methods have failed.

This type of rehabilitation has the further advantage of reducing the chances of relapse in recovered patients, since it is based on the sound principle of preparing them well for the social and economic aspects of the life they will live after they leave the hospital.

Chicago Council of Child Psychiatry Formed

A group of twenty-four child psychiatrists of the Chicago area have formed the Chicago Council of Child Psychiatry. The purpose of the organization is to further the exchange of information and ideas in the field of child psychiatry and those fields that pertain to the promotion of the mental health of children. The council will seek to encourage support and development of those community resources and services that contribute to these aspects of child welfare.

Officers elected for 1953–1954 are: Dr. George J. Mohr, president; Dr. Eugene I. Falstein, vice president (and president-elect); and Dr. George L. Perkins, secretary-treasurer. Other persons on the executive committee for the same period are Dr. Irene Josslyn, Dr. Sophie Schroeder Sloman, and Dr. Harry Segenreich.

Dr. Lawrence C. Kolb Appointed Director of Psychiatric Institute

Dr. Lawrence C. Kolb of Rochester, Minnesota, has been appointed director of the New York State Psychiatric Institute and professor of psychiatry and executive officer of the Department of Psychiatry, Columbia University, College of Physicians and Surgeons. Dr. Kolb will also be director of psychiatric service at Presbyterian Hospital.

At the Psychiatric Institute, which is the hub of the broad research and teaching program of the department of mental hygiene, Dr. Kolb

succeeds Dr. Nolan D. C. Lewis, who retired from state service last September.

At present Dr. Kolb is consultant in psychiatry at the Mayo Clinic, Rochester, Minnesota, and associate professor in psychiatry of the Mayo Foundation, Graduate School of Medicine, University of Minnesota. In addition, he holds various consultant appointments. Included are appointments on three committees of the National Research Council dealing with psychiatry, naval medical research, and problems of alcohol. In Minnesota, he also serves on the governor's advisory council on mental health and is chairman of the research advisory committee to the state commissioner of welfare. He is also consultant on the advisory committee to the counseling clinic of the Public Health Center of Rochester and to the National Multiple Sclerosis Society.

Fellowships in Child Psychiatry Available

Fellowships offering specialized training in child psychiatry are available in a number of member clinics of The American Association of Psychiatric Clinics for Children which have been approved as training centers by the association. *The training begins at a third-year, post-graduate level with minimum prerequisites of graduation from medical school, a general or rotating internship, and a two-year residency in psychiatry—all approved.* The majority of these clinics have also been approved individually by the American Board of Psychiatry and Neurology for a third year of training and for an additional year of experience.

This training is in preparation for specialization in child psychiatry, and especially for positions in community clinics devoted wholly or in part to the outpatient treatment of children with psychiatric problems. At the completion of training, attractive openings are available in all parts of the country. Fellows receive instruction in therapeutic techniques with children in outpatient settings that utilize the integrated services of the psychiatric clinic team. Most of the clinics have a two-year training period although a few will consider giving one-year training in special cases.

Fellowship stipends are usually in line with U. S. Public Health Service standards—that is, approximately $3,600—as these stipends come mainly from the Public Health Service. Stipends sometimes are paid by state departments of mental health, individual clinics, and occasionally communities paying for the training of psychiatrists who engage to work in these communities at the end of their training. Special arrangements may be made occasionally to supplement the stipends by taking on other responsibilities locally—*e.g.*, part-time work with the Veterans Administration, consultation to social agencies,

etc. A limited number of training centers can offer higher stipends.

The office of The American Association of Psychiatric Clinics for Children acts as a clearinghouse for applicants. Application may be made through this office or directly to the individual clinics. In all cases, acceptance of applicants for training is by the individual training centers.

For further information and for application forms, write to: Miss Marion A. Wagner, Administrative Assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19, New York.

Residencies Available in Veterans Administration Hospital

The Veterans Administration Hospital, Lyons, New Jersey, has available residencies in psychiatry for a one-to-three-year period. These residencies are fully accredited by the American Board of Psychiatry and Neurology. The training program consists of lectures, conferences, and seminars under the direction of the Department of Psychiatry, New York Medical College. It offers intensive training, both intramurally and through rotation in special hospitals and clinics in the adjacent area. There are, in addition, a number of guest lecturers, as well as an annual institute at the hospital. Training may begin at any time.

Teaching and Research Assistantships Available at Pennsylvania State College

The Department of Child Development and Family Relationships of the School of Home Economics, The Pennsylvania State College, State College, Pennsylvania, is offering several teaching and research assistantships for the academic year 1954–55. New students are eligible. Twenty hours' work per week is required, and 9–11 semester credit hours' work may be scheduled. The stipend is $1,180 per year, plus tuition; other positions are available. Current research includes investigations of relationships within three-generation families; rôle conceptions of husband, wife, and child; longitudinal studies of nursery-school children and their families; and social-psychological adjustments in retirement. Apply for admission to Dr. H. K. Schilling, Dean of the Graduate School. For assistantships apply to Dr. Grace M. Henderson, Dean of the College of Home Economics.

The National Foundation for Infantile Paralysis Offering Fellowships

The National Foundation for Infantile Paralysis announces the availability of a limited number of post-doctoral clinical fellowships

in physical medicine and rehabilitation to candidates who wish to become eligible for certification in that field.

Fellowships will cover a period of one to three years at training centers that have been approved for residencies in physical medicine and rehabilitation. Stipends to fellows are based on the individual need of each applicant. Appropriations of $475,000 in March of Dimes funds have been made to cover the cost of the program.

Eligibility requirements include United States citizenship, graduation from an approved school of medicine, completion of at least a one-year interneship in an approved hospital, and a license to practice medicine in at least one state. The age limit is forty. Selection of candidates will be made on a competitive basis by a clinical-fellowship committee composed of leaders in the fields of medicine and professional education.

In additional to these full-term fellowships, the foundation is making available a limited number of short-term fellowships to physicians who wish to become better acquainted with physical medicine and rehabilitation as it relates to their particular specialties. Such training is being offered to physicians who, in addition to meeting the other requirements, have completed a minimum of one-year residency in orthopedics, pediatrics, neurology, or internal medicine. For these fellowships—which will cover a period of training of three months to one year at centers that place special emphasis on physical medicine in relation to the applicant's specialty—the National Foundation has provided a special appropriation of $51,050.

Complete information concerning qualifications and applications on both types of fellowship may be obtained from the Division of Professional Education, National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

New Journal Started in the Field of Criminal Psychodynamics

Announcement has been made of the completion of plans for a new quarterly journal, *Archives of Criminal Psychodynamics*, to be printed by the Lord Baltimore Press, with Ben Karpman, M.D. as editor and Melitta Schmideberg, M.D. as associate editor. The rest of the editorial board is being formed and at present consists of the following: Walter Bromberg, M.D.; Jacob H. Conn, M.D.; Wladimir G. Eliasberg, M.D.; Arthur N. Foxe, M.D.; George E. Gardner, M.D.; Leo Kanner, M.D.; Samuel B. Kutash, Ph.D.; Lawson G. Lowrey, M.D.; Sydney B. Maughs, M.D.; and Lester W. Sontag, M.D. Foreign correspondents and contributors are: Jose Belbe, M.D., Buenos Aires, Argentina; Mme. Marie Bonaparte and Daniel Lagache, M.D., Paris, France; Edward Glover, M.D., London, England; and Kenji Ohtsuki, M.D., Tokyo, Japan.

The *Archives of Criminal Psychodynamics* will be psychoanalytically oriented. It will devote itself to the encouragement of research into the psychodynamics of antisocial and criminal behavior, and interpretation and dissemination of the existing knowledge of the same; the promotion of superior legal and humane understanding of the relations involved between the criminal and the society in which he lives; and the betterment of the condition of the criminal as an individual. It will attempt to crystallize all available thoughts on the subject. It will, therefore, publish original articles dealing with all phases of antisocial and criminal behavior. It will attempt to correlate these with other psychiatric and extra-psychiatric disciplines, such as sociology, criminology, anthropology, biology, and medicine, as they appear to relate to the problem of antisocial behavior.

The first number is scheduled to appear this spring. Inquiries and manuscripts will be promptly acknowledged and answered. Further information may be obtained from the editor, Ben Karpman, M.D., Station L, Washington 20, D. C.

American Eugenics Society Issues New Journal

The first issue of a new journal of the American Eugenics Society, *Eugenics Quarterly*, made its appearance in March. The new publication takes the place of the former quarterly, *Eugenical News*. The editorial board of the new journal is made up of Frederick Osborn, chairman; C. Nash Herndon, M.D.; Frank Lorrimer; and Helen Hammons, managing editor.

The articles in the first issue include *Future Fertility of American Women*, by Pascal K. Whelpton; *Heredity of Joint Diseases*, by Robert M. Stecher, M.D.; *Family Allowances in Great Britain, Canada, Australia*, by Rosalind Chambers; *Sex Education and Eugenics*, by Jacob Goldberg; *Symposium on Genetic Factors Affecting Intelligence*, by J. P. Scott and others; *Research in Marriage and Family Life*, by Reuben Hill; *A Case in Heredity Counseling*, by C. Nash Herndon, M.D.; and *The Burgess-Wallin Report*, by Joseph Folsom.

The subscription price of the quarterly is $3.00. Subscriptions may be sent to American Eugenics Society, 230 Park Avenue, New York 17, N. Y.

Courses Available

A diversification of training opportunities for teachers and other professional workers with exceptional children characterizes the 1954 Summer Session Program in Special Education offered by Teachers

College, Columbia University. Professional preparation leading to advanced degrees and diplomas will be offered in the following areas: the mentally retarded, the physically handicapped, the deaf and hard of hearing, and audiology. In addition, a number of general courses in the field will be open to specialists and non-specialists. Provision is made for mature students who desire professional preparation without matriculation for graduate degrees or diplomas.

The program in mental retardation will center around two groups of children taking part in a comprehensive educational program. One group will consist of children with retarded mental development for whom an education program is planned. The second group will comprise children who are mentally deficient and for whom a training program has been established. Methods courses in both areas will be integrated with the on-going education and training of these children. Students may enroll for courses in the observation and participation in programs for the mentally retarded or the mentally deficient. In either case, a unified graduate program will coördinate training in methods, philosophy, and psychology with direct observation and participation. In addition, students may elect courses in the psychology of the mentally retarded, occupational skills, occupational education, and tests and remedial work for the mentally retarded.

Students preparing for work with the physically handicapped will have opportunities to select courses from the following offerings: psychology of the physically handicapped, health problems of physically handicapped children, education and care of the physically handicapped, education and care of the cerebral-palsied child, and techniques for functional living with physical disabilities.

The offerings in the area of hearing handicaps will be high-lighted by a six-week seminar in the education of the deaf, which will be offered in coöperation with the Lexington School for the Deaf. Students may register for the whole workshop or for either half. The first three weeks will be devoted to a study of auditory training and nursery and preschool work for the deaf. The second three weeks will deal with speech for the deaf. A course in the auditory and vocal mechanisms will also be given in coöperation with the Lexington School for the Deaf. Two courses in audiology—the measurement of hearing and audiology—will be offered in coöperation with the Presbyterian Hospital of the Columbia Medical Center. Two courses in this area—methods of teaching lip reading to the hard of hearing and auditory training for the hard of hearing—will be offered in cooperation with the New York League for the Hard of Hearing.

Several new courses feature the offerings in the general area of special education. Dr. Maurice H. Fouracre, Head of the Department

of Special Education, will offer a course in the administration and supervision of special education, designed for advanced students and administrative personnel. In addition, Dr. Fouracre will offer a course in teaching the slow learners.

Along with an introductory course in special education, general offerings include: counseling the parents of handicapped children, case-work and guidance of the handicapped, problems in special education, and psychology and education of gifted children.

The regular six-week summer session will be supplemented by two workshops to be given in June, 1954. The field workshop in rehabilitation training, offered in coöperation with the Institute for the Crippled and Disabled and the New York School of Social Work, will provide for participation in a rehabilitation-center program, coupled with lectures, demonstrations, team meetings, case conferences, and visitations. A limited number of advanced students and rehabilitation workers will receive intensive practice under skilled supervision. In addition, a work conference on audiometry in education and industry will be offered. This conference will be held from June 7–25, for teachers of the deaf and hard of hearing, employment and guidance officers dealing with the hearing handicapped, medical personnel, and social workers. The conference will provide intensive training in administering, interpreting, and using the results of hearing tests.

Further information about all or part of this summer session program in special education at Teachers College may be obtained by writing to Professor M. H. Fouracre, Chairman, Department of Special Education, Teachers College, Columbia University, New York 27, New York.

Intensive workshops in guidance and instruction of the adolescent and adult with cerebral palsy will be held this summer at three graduate schools of education. The workshops are being sponsored by United Cerebral Palsy in coöperation with the host schools. Scholarships will be available.

The workshops are being held to assist teachers, counselors, social workers, therapists, nurses, and personnel in related fields in providing realistic vocational counseling to the cerebral palsied.

The scholarships, covering tuition and material costs, maintenance and travel, are available to persons who wish to continue their study for professional advancement or to complete degrees. All applicants must have the necessary prerequisites for admission to a graduate school.

The workshops will be held at Boston University, Boston, Mass., June 28 to July 8; University of Kentucky, Lexington, Ky., July 9

to August 3; and Temple University, Philadelphia, Pa., August 10 to August 31.

The course values of these sessions will be three semester hours or credits. Appointments will be made for the summer session only.

Further information and scholarship application forms may be obtained from Mr. Ernest Fleischer, Chairman, Adult Vocational Advisory Board, United Cerebral Palsy, 50 West 57th Street, New York 19, N. Y.

Announcement of Meetings

The International Congress for Psychotherapy, to be held in Zurich, Switzerland, July 20–24, under the patronage of the Swiss Association of Medical Psychotherapy, will have as its subject "Transference in Psychotherapy." M. Rodolphe Rubattel, President of the Swiss Federal Council, is honorary president of the congress.

The aim of the congress, as stated in its preliminary announcement, is "to throw light on that human relationship between patient and psychotherapist which Freud denoted 'transference' and regarded as the pivot of all psychotherapeutic theory and practice. The main questions under discussion are: Did Freud's statements fully exhaust all aspects of the phenomenon of transference, or have new ones emerged in the course of the last fifty years? What importance is assigned to transference by the different schools of psychotherapy? Has deeper insight into the nature of transference had any influence on its practical application in psychotherapeutic treatment?"

The membership of the congress is open to all qualified doctors and to qualified non-medical practitioners who are members of a recognized psychotherapeutic association in their own country, or who are recommended by the president or two members of such an association in writing.

For further information about the congress, write the Secretariat of the International Congress for Psychotherapy, Theaterstrasse 12, Zurich 1, Switzerland.

The theme of the Fifth International Congress on Mental Health, which will meet at the University of Toronto, August 14–21, 1954, is "Mental Health in Public Affairs." There will be technical sessions each morning, organized around five major topics: Areas of Partnership in Mental Health and Public Health; Mental Health in Governmental Activities; Mental Health of Children and Youth; Community Partnership in Mental Health; and Professional Advances in the Mental Health Field.

In addition to the technical sessions, there will be round tables

designed to meet the interests of special groups of delegates on the following topics: Mental Health and Education; Parent Education; and The Rôle of the Volunteer in Mental Health Work.

The International Institute on Child Psychiatry, will meet prior to the Congress on August 13 and 14. Its theme is "The Emotional Problems of Children Under Six.

On Friday, August 13, small working groups will spend the entire day in discussing prepared clinical case studies. On Saturday morning, August 14, larger group meetings will consider research reports. The case studies and research reports are classified in four major areas: Psychosis in Children; Prevention; Interrelationship of Physical and Emotional Factors; and Maternal Separation. Institute registrants will be asked to select the area in which they are most interested. In so far as possible, assignment to group and section meetings will be made in accordance with their choice.

On Saturday afternoon, there will be a plenary session, with papers presented by Dr. Georges Heuyer, France; Dr. Emanuel Miller, Great Britain; and Dr. Benjamin Spock, United States.

The inclusive fee for both conferences, the congress and the institute, is $25.00; $20.00 if paid before June 1st. All fees and inquiries should be sent to the Executive Officer, Fifth International Congress on Mental Health, 111 St. George Street, Toronto, Canada.

The International Committee on Group Psychotherapy has organized the First International Congress on Group Psychotherapy, to be held in Toronto, Canada, in connection with the Fifth International Congress on Mental Health, in August, 1954. The conference will promote the exchange of information and intensify personal contact between workers in mental health and allied professions throughout the world.

A series of meetings have been arranged. Papers and symposia will deal with group psychotherapy and group studies in the areas of family relations and the national and international communities.

Therapeutic work with children and parents, adolescents and the aged, addicts and delinquents will be presented. The use of groups in education, in industry, in government, and in working with different ethnic groups are among the subjects with which panel discussions will deal. There will also be discussion groups dealing with various aspects of group psychotherapy and group studies during the week of August 16th.

Representatives of 23 nations are participating in the organization of the congress. Wilfred C. Hulse and Wellman J. Warner are chairmen; J. L. Moreno and S. R. Slavson, consulting chairmen.

For full details write to International Congress on Group Psychotherapy, Room 916, 1790 Broadway, New York 19, N. Y.

For the first time in its 43-year history, the Family Service Association of America will hold its 1954 biennial meeting on the West Coast.

Board and staff representatives from among the nearly 260 affiliate agencies of the association, in some 230 cities, will gather in the Hotel Statler, Los Angeles, September 8 to 10, for the sessions. The meeting will be held in conjunction with the 100th-anniversary celebration of one of the association's oldest member agencies—Jewish Family Service of Los Angeles.

A major factor in scheduling the 1954 biennial meeting in California, Clark W. Blackburn, general director of the association, reports, is a recognition of the swift population growth on the Pacific Coast, which makes this area a "veritable laboratory of family problems under changing community conditions."

"Because of the need for individualized services to aid families to cope with difficulties in everyday living, organization of family agencies has taken place, or is under way, in dozens of West Coast communities not previously served," stated Mr. Blackburn.

"Less Unhappy Living—Greater Strength for Society," will be the theme of the biennial sessions, which will emphasize that unresolved conflicts within families often lead to social tragedies for which the whole community pays. Accent will be on the prevention of family breakdown through early use of professional services.

Mr. Robert F. Nelson, Executive Director, United Charities, Chicago, is chairman of the planning committee for the meeting. Among the 18 varied sessions being developed are these: "Unhappy Living—Its Causes and Costs," "The Family Agency's Response to Changing Community Needs," "Increased Production in Family Agencies," "Family Casework with Boys Under Court Jurisdiction," "Marriage Counseling," "The Family Agency and Mental Health," "Direct Treatment of Children," "Treatment of the Aging," "Use of Psychiatric Consultation," and "Governmental Responsibility for Family Welfare."

Because of wide interest in the establishment of family-service agencies in the West, the biennial meeting will be opened up to community leaders and representatives of other social agencies in West Coast communities interested in family-service organization and development.

Persons from all parts of the world interested in services for the disabled will assemble at The Hague, Netherlands, from September 13 to 17, 1954, for the Sixth World Congress of the International Society for the Welfare of Cripples.

Representatives of the twenty-six national organizations that are members of the International Society are expected to attend the

congress, as well as representatives of the United Nations, World Health Organization, and other governmental and non-governmental organizations interested in services for the physically handicapped.

The congress will be held under the joint auspices of the International Society for the Welfare of Cripples and the Netherlands Central Society for the Welfare of Cripples, the affiliated national organization in Holland of the international society.

The program, through plenary sessions, demonstrations, panel discussions, and special meetings, will present analyses of developments throughout the world in services for the disabled and means for furthering such services in the medical, social, educational, and vocational fields.

Mr. J. M. Ravesloot, President of the Netherlands Society and mayor of the city of Almelo, has been designated president of the Sixth World Congress.

The International Society for the Welfare of Cripples is a federation of national voluntary organizations that provide services for physically handicapped children and adults. Founded in 1922, it has, for many years, been the outstanding organization of its type in the international field.

The society's program includes all phases of rehabilitation of the disabled—prevention, medical services, education, social services, therapy, recreation, and employment. It serves as an international clearinghouse for information about technical and social developments in rehabilitation services for the handicapped.

The services of the society are extended to persons and organizations throughout the world, both member and non-member, who are engaged in work for the benefit of the handicapped. The affiliated member in the United States is The National Society for Crippled Children and Adults, which has headquarters in Chicago. The central offices of the International Society for the Welfare of Cripples are located in New York. Mr. Konrad Persson, Director General of the Royal Pensions Board and Chairman of the Norrbackainstitute in Sweden, is president of the society.

Recent Publications

The first authoritative manual of information on the nation's rehabilitation centers has been published by the National Society for Crippled Children and Adults, the Easter Seal Society.

Rehabilitation Centers in the United States, one of the most useful recent publications in the field of service for the crippled, grew out of the First National Conference on Rehabilitation Centers, jointly sponsored by the National Society and the Office of Vocational Re-

habilitation of the U. S. Department of Health, Education, and Welfare. The booklet was compiled by Henry Redkey, consultant on rehabilitation centers for the federal department.

Mary E. Switzer, Director of the Office of Vocational Rehabilitation, in a joint statement with Mr. Linck, Executive Director of the National Society for Crippled Children and Adults, said:

"Comparable information on this scale has not been available before. It is our hope that this information, together with identification of some of the trends in center development and the proceedings of the working committees of the conference, will help meet the great need of the many persons, agencies, and communities interested in centers, for more definite information regarding them."

All of the centers listed participated in the conference, which was held December, 1952, in Indianapolis, Ind., under the joint sponsorship of the federal department and the national society. Chosen as representative of all U. S. centers, they are divided into six groups, including teaching and research, hospital, and medical-school-operated, community with beds, community outpatient, insurance, and vocational-rehabilitation centers.

The volume contains descriptions and statistics on every phase of rehabilitation procedure. It is available at $1.50 per copy from the headquarters of the National Society for Crippled Children and Adults, 11 South La Salle St., Chicago 3, Illinois.

A booklet for physicians, *Psychological Factors In The Care of Patients With Multiple Sclerosis,* by Dr. Molly B. Harrower, New York psychologist, and Rosalind Herrmann, Boston social worker, has recently been published by the National Multiple Sclerosis Society.

Multiple sclerosis, the booklet states, is not only chronic, but usually progressive, and unpredictable in its attacks, so that uncertainty plus fear of the future plus worries of the present combine to give its victims an unusual share of anxiety. Since no cure for the disease is known, there are unique aspects in the relationship between doctor and patient.

For instance, it has been established that emotional growth occurs not so much in pleasant periods of life, but when one is stimulated by difficulty in distressing situations. A doctor, therefore, can assist a patient to discover actual satisfaction in coping with his liabilities; he can help the patient feel a sense of challenge and even make this challenge to overcome his handicaps a purpose in life. Once a patient can be made to understand that the greater his emotional maturity and stability, the less his "disability," he will be helped over a large hump.

If the doctor does not maintain a wary eye on his own emotions,

he may find his behavior toward his patient typical of the boiling point of frustration, because it is in his nature to want to heal, to cure. If he is not careful, he may transfer disappointment and pessimism to his patient and so do grave emotional harm. Actually, there is enough in the multiple-sclerosis situation to warrant hope, and the doctor should approach his patient with the thought uppermost that, though there is no known cure for the disease, many things can be done about it. Nature itself, the wonders of the patient's own body, resistance, can do much to help. About 17 per cent of these patients achieve lasting remissions, a state in which they may get much better. Also, statistical findings prove that their lives are not much shorter than that of the average individual.

Dr. Harrower states that the optimum solution for the multiple-sclerosis patient is the maintenance to the greatest extent possible of his way of life prior to his illness. In some cases, it is advisable for the individual to find a new means of income suitable to his altered capabilities; in other cases, he might strive to remain in the same career or trade. As regards the problem of employment, Dr. Harrower reminds hopefully: "Confronted with the need to adjust an increasing number of handicapped in a world of war casualties, many communities have developed a greater interest in the handicapped individual. . . In the rehabilitation effort, we have enlisted the businessman as well as the social agency. . ."

The booklet also states that membership in the National Multiple Sclerosis Society, an organization with 34 chapters and about 30,000 members, devoted to research and service in multiple sclerosis, is of great psychological value for victims of the disease. By identifying themselves with this organization, these patients achieve a sense of common interest and have the feeling of coöperating with many others in helping to solve their own problems.

Physicians may obtain the new booklet by writing to the National Multiple Sclerosis Society, 270 Park Avenue, New York City. Its companion booklet, for patients, released at an earlier date, *Mental Health and M.S.* by Dr. Molly R. Harrower, is still obtainable and may be had free of charge by writing to the society.